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ADVANTAGES OF HOME NURSING IN COMMUNICABLE DISEASE

A Survey of the Communicable Disease Hospital Needs of the Borough of the Bronx in New York City has just been completed* which presents some remarkable figures on the success of home nursing care of such cases by public health nurses (Henry Street Visiting Nurse Service) as contrasted with hospitalization. We quote from the Survey**:

"The home care of patients with communicable diseases under organized visiting nurse auspices is a community resource for the care of contagion recognized as of outstanding importance, both as an effective control measure for their prevention and because of its low cost as contrasted with hospital care. The low mortality among the patients under private medical care using the nursing service bears eloquent testimony to the favorable results of a high grade quality of visiting nursing in the care of contagion. The ratio of deaths to cases is extremely low."

The frequency with which fatalities occur among Henry Street Bronx patients with acute communicable diseases contrasted with the cases reported for the borough as a whole, is shown in the following table, which lists these facts for the year 1931, and the five-year average for 1927-1931.

RATIO OF DEATHS TO CASES FOR HENRY STREET BRONX PATIENTS AND FOR ALL REPORTED CASES 1931, AND AVERAGED FOR 1927-1931

	Ratio of Deaths to Cases, 1931				Ratio of Deaths to Cases Averaged for 1927-1931	
	Henry Street Deaths	Cases Ratio	Total Bronx Deaths	Cases Ratio	Henry Street	Total Bronx
Diphtheria	2	1 to 17	24	1 to 24	1 to 43	1 to 21
Scarlet fever	1	1 to 434	27	1 to 153	1 to 1185	1 to 177
Measles	None	(630)	12	1 to 457	1 to 598	1 to 188
Whooping cough	2	1 to 78	35	1 to 42	1 to 38	1 to 30

*Survey made by Anna C. Phillips for the New York City Visiting Committee of the State Charities Aid Association in coöperation with the Department of Hospitals and Department of Health, 1932. Copies of this study may be obtained from the State Charities Aid Association, 105 East 22d Street, New York City.

**Pages 45 to 52.

Quoting further:

"The cost of Henry Street Visiting Nurse Service is $1.15 a visit. This includes all of the expense of conducting the service, namely, maintenance of the central and branch offices, transportation, nursing equipment, salaries, etc.

"The number of visits required for the care of children with acute communicable disease varies. Some patients require bedside nursing while others, where the mother is teachable and intelligent and can give the nursing care, need only occasional supervisory visits. The 7,787 visits made in 1931 to Bronx patients with contagion indicate an average of 6.2 visits to each case, representing an average cost of $7.13 per patient.

"The average daily cost per patient of communicable disease hospital care in New York City, as in other cities in which they are used only for contagious diseases, is high.

"At Willard Parker Hospital, which receives the majority of the Bronx cases of the four diseases in question which are hospitalized, the average annual cost of caring for one patient for one day in 1930 was $8.86 (not available for 1931). Based upon this figure, and the average number of days patients were hospitalized, the cost of hospital care of each case of diphtheria in 1930 was $111, scarlet fever $234, measles $85, and whooping cough $194.

"Without attempting to discuss a major issue such as formal provision by the city of home nursing care, in addition to hospital care, for cases of contagion, attention is called to the low mortality, the control of the spread of contagion, and the marked economy of visiting nurse care under competent, organized auspices.

"When it has been found that visiting nurses, going from home to home, without one recorded instance of infection carried, can provide satisfactorily for so large a proportion of the contagion, with so low a mortality, at a fraction of the cost of hospital care, the desirability of employment of this method by the city warrants serious consideration; reserving the hospitals for the severe or complicated cases, or for those for which home isolation is entirely impossible."

WHAT KIND OF A "NATIONAL" IN 1933?

To live within its income is the duty of an honest organization as well as of an honest man. The National Organization for Public Health Nursing has lived within its income during the last few years, especially during 1932, although it has been difficult to make the dollars take care of all the services that were requested. We have not lived on the same scale in 1932 as in 1931, however. We have economized, dropped some services, cut salaries, and made every cent stretch as far as it will. We feel we are giving the best service we can on our present funds. 1933 presents a very crucial situation. If our income decreases from any one source—particularly from membership, which is our most important support—we must drop more services and curtail others. We believe that you, the readers of PUBLIC HEALTH NURSING—many of you members, many of you potential members—would not want us to fail in our service to the field in this period when public health nursing needs all the help it can receive from a national organization. Curtailing income means letting go unanswered such letters as the following—typical of the kind we are receiving constantly:

(1) From a health officer—Will you please tell me what advantages there are in having a nurse supervisor for our staff of eight nurses carrying the Health Department service? We have no supervisor. I believe we should have one, and I would like arguments to present to our taxpayers to convince them of the need. At a time when economies are the order of the day, this is not easy.

(2) Or this—We must cut our budget 10 per cent. Shall we cut salaries, program, or staff? What are other agencies doing about vacations?

(3) Or this—From a rural nurse: Can you tell me some of the arguments being used to support service to well babies? We are threatened with a cut. Please send suggestions for newspaper publicity also.

(4) Or this—From a board member: Can you come to ——— and give us an institute on board organization and publicity? We are reorganizing and our board and the community need waking up.

(5) Or this—We are making a study of the nursing needs of our city. Please tell us how many nurses are needed in a city of 150,000 and what should be their relation to social workers.

(6) Or this—I want to take a course in public health nursing, emphasizing rural work. Where can I go?

(7) Or this—Have you any posters we can use in our campaign to advertise our

service? Please send suggestions for an annual meeting.

(8) Or this—From a school nurse: Please tell me whether school nurses are giving relief. Should a school nurse administer a relief fund if there is a Family Welfare service in the community?

(9) Or this—Please send us at once evidence which proves and supports the value of the school nurse's work.

(10) Or this—How do you estimate the cost of student service? Should their lunches be charged to the cost of our nursing visits?

(11) Or this—We are planning a series of staff educational conferences. Please send suggestions.

(12) Or this—Plans are under way to combine our child welfare work with the city department program. Please send all the information you have on combined official and non-official services.

(13) Or this—Our city is going to have a community chest. Should we become a member agency?

(14) Or this—We have not had a visiting nurse here in years. We need one. Please tell me where I can get a nurse, how much she would cost, and how to help her get started.

(15) Or this—A country-wide study is being made of the effects of the depression. Please send us a statement for publication as to the effect on public health nursing.

Or this—or this—or—Yes, we could go on at length drawing out typical letters from our mail bag. Suppose we had to say "no" to any of these requests? In each of these examples of local need there is something which touches the nationwide progress of public health nursing very closely. Read them over—think about their answers. If your National cannot answer them, who will? If your National does not answer them, what will happen to public health nursing?

This is not a year when we can afford to let even one letter go unanswered—even one call for help be refused. Frankly, your three dollars may make this difference to us. We are not hiding the fact that we need your membership as never before. Even during the war, the question of support was not so vital as now. Either we hold fast to our standards in 1933 through a living, active National, or we slide back ten years, weakly trying to keep the skeleton of a national organization with a depleted staff and contracted service.

The membership enrollment for 1933 has started. The extent of N.O.P.H.N. service rests with every individual engaged in public health nursing.

SOPHIE C. NELSON,
President, National Organization for Public Health Nursing.

N.O.P.H.N. CERTIFICATE OF HONOR WINS AWARD

Local organizations which have received a 1932 Certificate of Honor for 100 per cent nurse membership in the N.O.P.H.N. will be interested to know that the Certificate has been selected to be a part of an annual exhibit of fine printing which is sponsored yearly by the American Institute of Graphic Arts of New York.

The exhibit has been on display in New York City at the Art Center during October and will be sent on a tour of the country where it will be exhibited in museums and libraries in some twenty cities throughout the United States.

The Certificate of Honor in a new color will be awarded again in 1933 to every agency reporting 100 per cent nurse membership in the N.O.P.H.N.

Self-Analysis by a Board Member

Editorial Note: These searching suggestions come to us from Mrs. James G. Horan, Secretary of the Scranton (Pa.) Visiting Nurse Association. They were presented at a Board Members' Institute in the spring of 1932.

AS the responsibilities of a Board Member become more and more complex and her rôle at the same time becomes more important in community life, it behooves her to stop and take stock of how nearly she is measuring up to what is expected of her. She may well ask herself these questions:

1

One of the duties that confronts every Board Member is the *selection of new Board Members* to fill vacancies that occur from time to time, so the first question that I must ask myself, as a Board Member, is this: In the selection of new Board Members, am I making my choice because of some specific contribution that the new member has to offer? Do I select the new member because she happens to be a particular friend of mine, whom I would enjoy having on the board, or because her social position makes her name a desirable one to have on a list of directors? Or, on the other hand, do I consider that, because of her connection with a particular racial or religious group, and her own peculiar qualifications, she will be able to bring to the Board a new point of view and be able to interpret to the Board, the reaction of her particular group to the problems under discussion? Again, the new member may be chosen because of the mature judgment she may possess, an invaluable quality in any Board Member. Another person may bring to the Board a special talent for financial or legal problems.

We are agreed that the ideal Board should represent a cross-section of the community, and to attain such an ideal we should strive to select representatives from as many groups as possible so that the problems of the Board may be considered in their relation to the problems of the community. In selecting new Board Members, we should remember also that a smoothly functioning board cannot be made up entirely of aggressive personalities. We need leaders, of course, but we also need those, who through this leadership, can carry on smoothly and efficiently the work of the board.

2

The next question that I ask myself, in determining my qualification as a Board Member, is this: *Am I sufficiently informed as to the policies of my organization to be able to interpret them clearly to outsiders, without creating misunderstanding?* As Board Members we form a link between our organization and the public, and we should be able to discuss intelligently any question that outsiders may ask us about the work of our organization. For instance, in the case of the visiting nurse association we should be able to explain about the patients' fees, the arrangements for hourly nursing service, the salaries we pay our staff. We should be familiar with the function and set-up of the clinics, how the work of the clinic is followed up in the home. We should know that no case is accepted for nursing care by the organization without a physician in charge. In other words, we should act as interpreters of the policies of the organization to the public which supports our work.

3

Again I ask myself: *Am I informed? Do I know the resources of my community and how to employ them?* In Scranton, a Board Member should know something of the other organizations in the Community Chest. We should be familiar with the work of the other social agencies not in the Chest, so that,

if our work presents a problem that could be aided by their coöperation, we would know how to secure their aid.

In this same connection I may ask myself: What do I know of the functioning of my local Board of Health? Have we a full-time health officer? Have we adequate milk ordinances? Does the Board of Health provide financial assistance to any of the nursing organizations of the community? Has it a group of nurses of its own? Does it provide sufficient funds for municipal hospitals? What is it doing to control communicable disease? What was the result of the Health Survey made in Scranton several years ago? What has been done to carry out its recommendations? As a Board Member do I feel responsibility toward improving and bringing about in my community an ideal Board of Health?

These are all important questions in the health program of a city, and, as Board Members, we should be concerned about them.

4

How shall I answer this question: *Am I interested in the general public health movement and do I make an effort to keep myself informed?* If so, newspaper articles take on a new significance. I am as much interested in a typhoid epidemic in Kalamazoo, as I am in the social column. The magazine, PUBLIC HEALTH NURSING, becomes as much a part of my monthly reading as the latest novel. In this way I acquire general information, and keep abreast of what is being done in other communities.

We have been considering our own local organization and its relation to our own community. What about our relation to the National Organization? Am I a member of the N.O.P.H.N. and do I feel responsibility beyond my own organization? This is a difficult question for me to attempt to answer; some Board Members feel that it is important for officers of a Board to belong to the National Organization, while others feel that every Board Member should belong.

5

Then, too, I am concerned with how we can continue to develop and not become self-satisfied. Let me ask here: *What is the value of attending large group conferences* which will give stimulation and a better perspective in guiding my own organization? We should welcome opportunities to learn from the experience of others, so that we may be better enabled to judge our own problems, and if our larger experience teaches us something that will be useful to others, we should be willing to give of ourselves and share this knowledge.

6

If I am a Board Member who is really informed about the actual details of my organization, *should I not be capable of rating my organization,* in comparison with other public health nursing organizations, in such special aspects as *adequacy of supervision, efficiency of record keeping, salaries, hours,* and *development of special service?* I should know how many supervisors are needed to provide for an efficient functioning of the staff. I should be able to judge whether or not these supervisors are adequately equipped for their task. In the matter of record keeping, we should be able to judge whether our records are valuable in giving a concrete picture of the work we are doing and a basis of measuring our work. We should know, through our National Organization, whether or not we are paying salaries comparable with those of other agencies. Are our hours of work in accordance with the hours generally accepted by other organizations in the same field?

How does our organization compare with others in the development of special service? Have we a delivery service? Should we be considering this gap in our program? Is our baby welfare program adequate for the community? Are we reaching the right groups? Have we sufficient nurses to do the important follow-up work in this service? What about our tuberculosis program? This particular disease is especially important just now, as the unemployment

situation with its resultant conditions of under-nourishment is bound to bring about an increased tuberculosis case load. And communicable disease nursing: What percentage of cases not sent to the Municipal Hospital are receiving intelligent nursing care?

All these questions are directly connected with this matter of being informed about the work of our organization, as well as being conversant with the wider aspects of the whole public health nursing field. In the latter connection, still another question is suggested: Do I feel strongly about the close relationship between my organization and other health developments in the community? If there are gaps in the community health program, is it our responsibility to fill them?

7

If I really wish to know how conversant I am with the *details of my organization,* I might ask myself: Am I competent to judge whether or not the report given by the superintendent is comparable with moneys expended? Here I ask myself a really pertinent question—should every Board Member be able to answer this question or is it primarily the province of the Finance Committee?

8

Besides a general knowledge, there is another quality that is supremely important in a Board Member, and that is *discretion.* Do I consider the affairs of the Association as absolutely confidential? If I am to act as interpreter between the board and the community, there are certain things that I shall have to discuss with others. Here is where discretion is all important. I must be able to discriminate between what should and what should not be discussed outside.

9

If I am to be an intelligent Board Member, here is another question I might ask myself: ***Am I interested in reports on individual cases merely from the emotional human interest standpoint*** *or do I analyze them from the medical social angle?*

It seems to me that we have long since passed the emotional period in our development and are now much more likely to be concerned with the basic causes of conditions and their remedies.

10

What contribution do I make to Board Meetings? It seems to me my greatest value to the meeting is to be alive to reports as they are given, and not to be hesitant to enter into discussion. This does not mean that the member who talks the most is making the greatest contribution, but rather the person whose opinions represent the result of constructive thinking. Is it fair for me to allow someone else to do my thinking for me, making all my decisions for me, carrying my responsibility which should be my own obligation? Often new Board Members feel that they are not qualified to participate in the affairs of the organization, but it is only through assuming such responsibility that they really become vital parts of the organization.

Going back to the *"yes" member:* I am thinking of the person who by her silence gives consent to certain actions taken and who no sooner gets outside the meeting, than she voices the opinion that she heartily disapproves of the action taken. I am sure that all Boards would prefer frank open discussions within the meeting.

What is my attitude toward the person who does not blindly accept everything that is said but who is analytical and wants to know more than a general summary? Should I regard such a person as an agitator or rather as a wide-awake, conscientious Board Member?

11

Since the aim of every Board is to arrive at decisions through constructive group thinking, each of us is expected to contribute to this collective thinking. If I feel free to express my own opinion, *am I tolerant of the opinion of others?* How am I to profit by the experience of

others if I am not willing to listen to and consider their point of view? Am I always positive that the way we are doing a thing must necessarily be the only way of doing it? Can I be more open-minded and more sympathetic with the proposal of new policies and ideas?

12

If I am to be conversant with the affairs of my organization it is important that I attend meetings. *Am I conscientious about attending Committee and Board Meetings or do other interests have precedence?*

13

When I become a member of a Board, I assume certain definite obligations. *Do I feel my responsibility as much as if I were a paid employee?* A Board which dispenses, in the course of a year, thousands of dollars of public funds, has a tremendous responsibility. Its members should feel that it is their duty and privilege to contribute the very best of their time and ability to the faithful administration of the work. In accepting these duties we should consider our physical fitness for the task in hand and we should be sure that we are able to give the energy needed to carry on.

14

Now that I have accepted certain obligations: *Is it right for me to continue as a Board Member if I am not in sympathy with the policies and cannot, in justice to myself, be loyal to the organization which I serve?* If I am not loyal to the organization, how can I expect loyalty in others? As members of a Board we should be willing to stand our ground and defend the policies of the organization.

15

In measuring my value to the Board I might use two yard-sticks; first, the growth and development of the work, and second the growth of other Board Members. *Am I making a contribution relatively as important as those who have served for the same period of years?*

16

As a result, perhaps, of the complexity of modern life, many of us find ourselves invited to serve on several Boards of Directors, and so I ask myself: *Has my membership on this Board been of value in contributing to other Boards and vice versa?* This condition ought to bring about a valuable interchange of ideas. We might ask ourselves here, whether we are contributing to the Board or the Board to us? Are we really giving something of ourselves to the organization and thus contributing to the welfare of our community?

And now that I have asked myself all these searching questions, and analyzed my motives, and abilities, and discovered my shortcomings and my assets, what is my conclusion? *What do I think of myself as a Board Member?* Of course the first thing that will come to my mind is the suggestion that all this applies to lots of people, but naturally not to me; my next reaction is apt to be: Why, I had better resign from the Board; I can never live up to all this; no one person could possibly possess every one of these qualifications. But I must remember that it takes time and infinite patience and study to attain perfection in any line of endeavor. If I have recognized that my capabilities for performing this important job fall short of its requirements, I have made the greatest advance in my progress as a Board Member. After all, the possession of an ideal, which we, perhaps, in ourselves may only approximate, gives us a goal towards which we may strive, for, as Browning has said,

"A man's reach should exceed his grasp,
Else what's a Heaven for."

Checking the Efficiency of a School Health Program

By WALTER E. HAMMOND

ONE of the most difficult features of any school program is that of finding the means of acquainting the parents of the community with the necessary information, so that they may judge wisely in relation to the success or efficacy of such a program. The community pays the bill and certainly has a right to know whether its money is being spent effectively or not.

Those in direct touch with the schools, such as the superintendent, teachers, and supervisors, get their impressions through the observation of change in the general tone of the school pupils as a whole. Because they see these pupils collectively, changes for better or worse are usually plainly evident to them. The parent, however, rarely sees the children in groups for a sufficiently long period of time or consistently enough to note any change, except in his own children, and in that case he is very apt to consider such change as due entirely to conditions provided by himself, in which the school has played no part. To him, the school health program will mean the carrying on of certain "health motions" which are prescribed by law and are done in such a way as to avoid breaking said law, but otherwise are purposeless, useless, and ineffective, or just mere "motions." The physical examination by the school physician results in filling out a large number of cards which are not used for anything at all. The dental examination results in the listing of a great number of defective teeth. Pupils are vaccinated, immunized against this or that, and to the layman, schools become very busy doing nothing. Even school board members come to feel that a school nurse's job is about done when the "examinations" are completed. Why are these opinions so wide-spread? The writer believes that it is because the chief executive, or school superintendent, becomes so busy getting things done, that he does not take time to compile the necessary information that would enable him to report to his constituency exactly what is going on, and how effective such work is. Again, all too often, the general opinion may be the correct one.

ANALYSIS OF PROGRAM

In matters educational, a school executive has a definite and scientific order of procedure. First of all he makes a survey of some particular field in order to determine whether difficulties exist there or not. Perhaps the survey reveals a weakness in a particular field. He then examines that field intensively, using diagnostic tests to determine the specific difficulties. Having located the particular defects, he inaugurates a scheme or system of remedial work designed to correct the known weaknesses. After this has had time in which to make its operation felt, he *checks* the efficacy of his program by again surveying the field. If he has been successful or is being successful, for even in educational fields few methods work 100 per cent, his survey will show the weakness corrected or an improvement being made.

Ordinarily an active superintendent can tell you just what the situation is, in respect to any recognized educational field. He can usualiy give you information concerning the status of the health information or "habits" being taught to the children, and can tell you whether the pupils "know" as much about health as they should, or whether some other community is succeeding in teaching this knowledge better. What he usually cannot tell you is, how effective are the physical ex-

aminations; how effective are the dental examinations; what does the nurse do other than "emergency work," after the examinations are over; what data have we to indicate that improved physical health means better work other than the sentimental cry that of course it does; has the work of the school nurse effected school attendance; etc. It would seem as if he had felt that responsibility within this field of health was outside his province. Ignorance of that field can be no excuse for him, for the superintendent whose experience in every field of education is such as to make him an authority in all fields is non-existent. In the same sense that a man is a wise one if he profits by his own mistakes but not necessarily a fool if he profits by the mistakes of others, so the superintendent who profits from this experience of others as well as his own is being exactly the kind of man he is supposed to be in order to occupy his position. He therefore accepts the field of health as one in which he is directly responsible for the outcome and applies his same scientific procedure to test its efficiency. Thus the physical and dental examinations become survey and diagnostic tests. The work of the nurse, the clinics, etc., become the remedial work. So far so good, but what about the resurvey, or check to determine whether the remedial program has been functioning?

With the above idea in mind, the writer has been "following" the health work, including examinations, etc., in the schools under his jurisdiction and is ready to submit the following facts for the consideration of his own community and for the citizenry at large who may have an interest in the health work of public schools.

Keene, New Hampshire, has a population of 13,775; 2,929 of whom are school children. The school health personnel consists of:

School Physician
School Dentist
School Nurse
Boys' Physical Education Director
Girls' Physical Education Director

DUTIES OF PERSONNEL

The school physician makes a physical examination of every pupil from kindergarten through the second year of high school, annually. His work consists of nose, throat, ears, chest, and heart examination, and his findings are recorded on individual cards by the school nurse who is in attendance. From his examination, he makes a diagnosis and gives specific recommendations for further medical or surgical attention for each pupil. In addition, the school physician examines every pupil who applies for working papers and passes on his physical fitness to go into the occupation in which he has secured employment. The school physician is also available to the school nurse for consultation in connection with any epidemic which may be prevalent. All in all he earns his money, and more.

The school dentist examines the teeth of all first grade, second grade, fourth grade, and eighth grade pupils. Pupils in the other grades are examined by him in case of trouble or suspected trouble. We select these particular grades for examination because it is in these periods that permanent teeth erupt, and if attention can be given at once, later trouble is prevented. The dentist does not work on the basis of seeing each pupil once, but on the basis of one four-hour clinic each week. By limiting our examinations to critical periods, more time is available for clinical practice of a corrective nature. As was the case with the school doctor, the school nurse is in attendance during the dental examinations and records the findings for each pupil.

DUTIES OF THE SCHOOL NURSE

The school nurse is one of the busiest people in the school system. First of all comes her work in connection with the physical and dental examinations, and the keeping of complete records. Second, her direct work in testing the eye-sight and hearing of all pupils above grade one, and recording her findings. Third, her direct service in rendering first aid and giving simple treatments where the teachers need help in emer-

gencies. Her big job, however, is woven into all three of those mentioned. Specifically, it is to see that everything humanly possible is done to correct the difficulties discovered by the examining physicians. In order to accomplish this, the nurse notifies every parent whenever there is need of medical, surgical, or dental attention to their children. She then organizes "drives" of one kind and another, all of which have as their ultimate aim the getting of each pupil who needs attention to visit his family physician or dentist for treatment. This is done by means of "100 Per Cent Perfect Teeth Campaigns," competitions between classes and between schools, health posters, the building of health castles, etc., all devices for the purpose of securing the coöperation of the pupil, and through the pupil's assistance, the coöperation of the parent. Where the pupil fails to respond, the nurse visits the home and makes her direct appeal for the welfare of her charges.

When the home contact fails to produce results and the economic conditions and the welfare of the child are such as would warrant such action, complaint is made to the proper authorities, charging neglect of children. This situation is comparatively rare; what is more common, is to find the attitude of the child and parent very good, but economic conditions such that the necessary attention cannot be afforded. Confronted with this situation, the school nurse is not daunted, but goes immediately to work establishing clinics to care for those cases which she has investigated and found unable to care for themselves. The dentist or doctor who can turn down a school nurse's plea for aid is hard to find, and various organizations such as the Red Cross, Rotary Clubs, Women's Clubs, Parent-Teacher Associations, etc., give gladly of their funds to meet the expenses of this work. You will note that this clinic work has developed wholly as a means of getting proper medical and dental attention to all pupils who need it. It is not a charity, and aid as aid, is not being extended to parents, but the condition of the child is of paramount importance, and according to a school nurse, must and shall have attention if needed.

Another activity of the school nurse is the weighing and measuring of each elementary school pupil. She also uses this information, properly charted, to make the pupils and teachers "health conscious." Pupils are taught what they should eat, how much they should sleep, and the best habits of breathing. Children ten per cent or more underweight are encouraged to take the mid-morning milk which is served at cost and as with the clinics, various organizations aid in paying for the milk needed by those unable to pay. Also because of the health value, proper sanitation is stressed, there is a daily inspection for clean hands, nails, clothing, etc. This work is checked by the nurse about once a month when she appears unannounced and inspects each child for cleanliness. Naturally this inspection spurs the teacher on to do her part more effectively. In addition to these continuous activities, the nurse keeps a complete disease record for each pupil so that in the event of a contagious disease breaking out in the school, she can immediately exclude for the period of incubation, all exposed non-immunes. If now one adds the multitudinous little treatments given directly in the school or by the parents under the nurse's direction, which serve to keep pupils in school who would otherwise be unnecessarily absent, one must agree that the average school nurse does not find time hanging heavy on her hands.

PHYSICAL EDUCATION

The boys' and girls' physical education directors are considered by the writer as a part of the child health program. The work of both directors is to provide suitable activities in the form of games and exercises that will aid in the more perfect development of the pupils' bodies. Corrective exercises are given to those pupils who need them for better posture, etc. The school nurse and physician advise with the directors in regard to difficulties that might not be apparent to the latter, such as weak hearts, etc. These physical education

directors reach every pupil through grade 10, once a week. The program calls for daily attention and this is done by the teachers who carry out the instructions left them by the physical education directors. These latter become very busy people when one considers that they oversee all school athletic teams, intra-mural as well as interscholastic, direct the coaching, organize and carry out game schedules, so that as many pupils as possible have an opportunity to compete in sports.

THE DENTAL PROGRAM

Let us first consider the dental program. In the school year 1930-31, all first grade children were examined by the dentist with the following results:

Number of first grade children examined	307
Number of pupils with defective teeth	91
Number of defective teeth	171
Number teeth corrected in clinic	115
Number teeth corrected privately	56

At the end of the last school year, 1930-31, all first grade pupils had 100 per cent teeth excepting some few where parents would neither have the necessary work done nor permit us to do it in clinic. The only permanent teeth to be found with grade one children are the six-year molars. These teeth usually erupt with a slight fissure in the middle that is not completely closed, hence the importance of early dental examination to correct this difficulty and save the teeth.

In the school year 1931-32 the teeth of all second grade children were examined with an idea of determining the effectiveness of the work of the preceding year. The results were as follows:

No. of second grade pupils examined	278
No. of pupils with defective teeth	125
No. of defective teeth	235

At first these figures were rather disheartening as they indicated an increase, but when a comparative study was made of these first and second grade records the following facts were revealed. First, that practically all of the *first* grade children whose teeth were 100 per cent on examination, were pupils whose six-year molars had not come through. In other words, they had no permanent teeth. Second, that practically all of the *second* grade children whose teeth were 100 per cent on examination, were pupils whose six-year molars had come through and been attended to in grade one. It is interesting to note that the average number of defective teeth per child, was the same for both grades, namely, 1.88 teeth. Third, that in order to insure the correction of six-year molars it is necessary to extend the work through grade two and this has been done.

The table at the bottom of this page will give an idea of the thoroughness of the work now going on.

This is really an achievement and it means that coöperation has been the slogan of all agencies involved, the home, the school, and the dental profession.

HOW IT IS DONE

The first thing that is done, of course, is the examination by the school dentist. This is done at the school building. The school nurse makes a record of the dentist's examination and if defects are found, sends a notice to the parent to that effect. The card bearing the notice also has a place for the signature of the parent in case he is economically unable to have the necessary dental work done but is willing that it be done in a free clinic. The next step consists of assigning the pupil a time to appear at the dentist's office where his teeth are attended to. Several appointments may be necessary. When work is completed, the pupil is given a card signed

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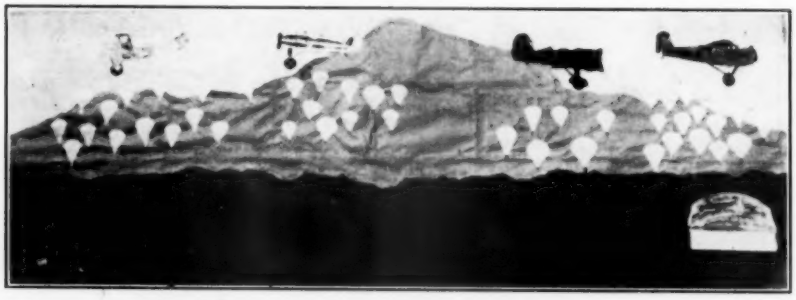
	Grade 1	Grade 2	Grade 4	Grade 8	Total
Number of pupils examined	247	278	222	188	935
Number of pupils 100% teeth	135	153	95	64	447
Number of pupils defective teeth on examination	112	125	127	124	488
Number of defective teeth	121	235	303	429	1088
Number of pupils 100% teeth at end of year	247	277	203	124	851

by the dentist stating that he has 100 per cent perfect teeth. It is evident that a 100 per cent card means that all possible corrections have been made, rather than such "perfect" teeth that dental attention was unnecessary. All of the local dentists were supplied with 100 per cent cards and willingly coöperated so that the work done privately was recognized. In past years some difficulty has been encountered in having parents unwilling to have the work done in clinic or otherwise. This year contests have been organized between classes and between schools so that the competitive feature has been utilized to the full. Various schools and classes developed some very unique and interesting posters as well as charts that displayed graphically the relative standings of the classes. These served to maintain the interest level of the pupils and have been very effective in producing results in homes not otherwise interested. Since these charts represent the effective part played in the program by the class-room teachers, their coöperation is very evident. As several of these were extremely interesting, photographs have been made of them and a description of those illustrated follows.

The first picture shows four aeroplanes flying over mountainous country. Each plane represents a grade and has a distinctive color. The proposition is to land safely so recourse is had to parachutes. As each pupil in a class received his 100 per cent teeth card he is permitted to drop from his plane and demonstrates his fitness by making a picture of a parachute from which is suspended a tooth, colors it to match the plane for his class-room and pastes it on the graph. Other pictures show balloon men selling balloons, or clowns carrying some. As in the first chart, each class has its own color and colors a balloon for each pupil who receives a card for 100 per cent teeth.

These contests seem to have solved the problem of parental coöperation because the children insist on having their teeth attended to.

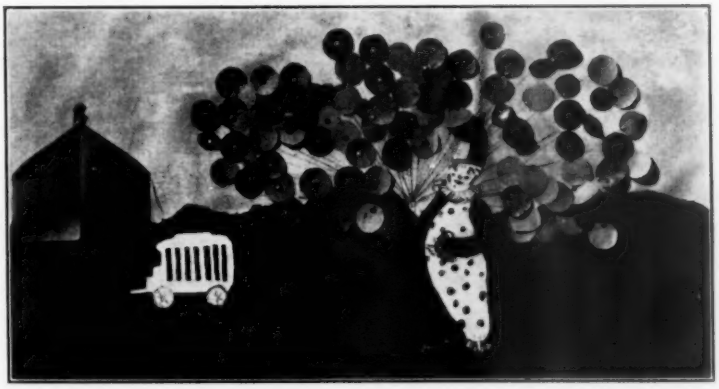
The local Parent-Teacher Associations gave and are giving excellent coöperation. Each group has had a meeting at which they have invited local dentists to speak on the value of dental hygiene. The coördinated effort has been so extraordinary that combined with the increase in clinic cases because of the unemployment situation, our clinic has been unable to attend to all of our cases. It is here that our local Dentists' Association demonstrated their fine public spirit. They voted to give a four-hour free clinic for every dentist in the association, thus supplying forty-eight more hours of clinical work. Like a rolling snowball, however, this gave such added impetus to the drive that even more time was demanded. Whereupon the various Parent-Teacher Associations dipped into their treasuries and provided funds for engaging more dentists' time for clinical service in their respective schools. It is very gratifying to find that several classes are 100 per cent classes, every pupil with 100 per cent perfect teeth. Even



Poster device used to secure pupil interest
How many parachutes will land safely?

the State Department has entered the lists and offered a banner for the first entire school with a 100 per cent teeth record.

A planned program, enthusiasm, coördinated effort, and a worth-while objective make up our recipe for successful dental hygiene. We believe that if we can carry our present program through for four years so that we may have the benefit of previous years' work, a single weekly clinic will be sufficient to maintain the standard we have set. From a school superintendent's point of view this phase of our health program is working effectively and efficiently. It has, in fact, developed into a community enterprise which insures its success. It is a goal worth striving for, "Every first, second, fourth, and eighth grade pupil in our schools with 100 per cent teeth by July 1st." To attain it means forty 100 per cent classes in our school system. It looks as though we would have more than 40 classes, as our third, fifth, sixth, and seventh grades have taken up the challenge and in several cases have a higher percentage of 100 per cent pupils than have some of our classes which have the advantage offered by the clinic service.*



A balloon poster. The colored balloons represent 100 per cent teeth—(See text)

DOES HEALTH WORK IN OUR SCHOOLS EFFECT ATTENDANCE?

A direct answer to this question is hard to obtain. We know well that having a school nurse has resulted in keeping individual pupils in school and likewise out of school. A glance at the following table shows quite clearly that the attendance has been getting better and better, although it is true that factors other than health supervision have probably been equally responsible.

Year	Per Cent of Attendance
1920-21	85 %
1921-22	91 %
1922-23	93.9%
1923-24	92.0%
1924-25	94.9%
1925-26	94.1%
1926-27	94.9%
1927-28	95.0%
1928-29	94.2%
1929-30	95.3%
1930-31	95.5%

Except as we keep a record of such cases as are kept in schools by the direct action of the nurse or as a direct result of health teaching in the schools, a matter difficult to do, we cannot know what part of the improvement in attendance has been due to our health program. A record should be kept for several years covering the causes of all absences and in that way we might ascertain positively the effect of health work on attendance. We are morally certain that it does tend to increase the per cent of attendance because of our knowledge of specific cases. The following tables showing the per cent of pupils neither absent nor tardy is probably likewise effected.

*See note at end of article.

TABLE 1
NO NURSING SERVICE

Year	Per cent neither absent nor tardy
1918	3.2%
1919	2.0%
1920	2.1%
1921	4.9%
1922	4.5%
1923	3.9%
1924	1.6%

TABLE 2
NURSING SERVICE

1925	4.9%
1926	5.3%
1927	6.5%
1928	7.5%
1929	4.5%
1930	7.3%
1931	8.8%

Each table covers a period of seven years, table 2 covering the period that the present nurse has been in our schools. Whether the marked difference between the tables is due to more effective work on her part is, of course, difficult to state. Records tend to indicate that the health service has been more efficient during the past seven years. However, the following tables showing the numbers of diseased tonsils found each year during the same periods, bear out this statement.

Without resorting to additional tables, reference to previous reports gives the following facts. In 1925 there were 239

TABLES 3 AND 4 SHOWING NUMBER OF CASES OF DISEASED TONSILS

No Nursing Service		*Nursing Service*	
Year	Number	Year	Number
1921	194	1925	325
1922	382	1926	211
1923	444	1927	125
1924	357	1928	125
		1929	120
		1930	56
		1931	49*

*20 corrected this year to date, in clinic.

pupils reported as underweight. In 1930, but 130 were so reported. In 1925, 37 pupils were reported unvaccinated without legal excuses. In 1931, the report shows no pupils unvaccinated without legal excuses. Likewise reports on vision defects show a steady lessening. Through the use of an audiometer or scientific ear-testing apparatus, hearing defects not previously noted have been detected and in many cases we have a record of correction or successful treatment.

All the evidence presented tends to show a positive improvement in health conditions in our schools as a direct result of maintaining a health program. It gives a great deal of pleasure to present these facts as to the value of health service and health teaching and thereby present a firm basis for forming judgments in this connection and do away with the necessity of surmises which may or may not be sound.

Note—Feeling very certain that any readers of this article would be interested in knowing the actual accomplishment in our 100 Per Cent Teeth Dental Program, the writer is attaching this note, describing some later developments in the work, and presenting the final figures. The enthusiasm developed was so great that advantage was taken of it and all grades were included, even the high school. Instead of waiting four years to feel the "effects" of our program, we will begin to benefit by them immediately.

The final records are as follows:

Fuller School	100%
Tilden School	100%
Wheelock School	100%
Washington School	100%
Symonds School	100%
Lincoln School	100%

Total number of 100% grades	43
Per cent for elementary pupils, K-6	92.49%
Per cent for junior high schools, 7-8	53.89%
Per cent for senior high school	64.56%
Per cent for entire city of Keene (all public schools)	78.51%

Welfare and Relief Mobilization

The N.O.P.H.N. is representing its members throughout the country by being one of the twenty-eight national agencies coöperating in the Welfare and Relief Mobilization for 1932. This is a great concerted effort to arouse the American people to a new faith and a new belief in social work and to encourage vigorous local, state, and national effort to provide the means for meeting this winter's anticipated social needs.

Miss Katharine Tucker represented the N.O.P.H.N. at the National Conference held in Washington, D. C., September 15, which was opened by an address by President Hoover. Mr. Newton D. Baker presided as Chairman of the National Citizens' Committee.

Excerpts from some of the speeches reflect the courageous spirit of the meeting and give new slants on old problems. Some of these excerpts may be useful for local quotation.

President Hoover:

"Our tasks are definite. The first is to see that no man, woman, or child shall go hungry or unsheltered through the approaching winter."

"This is, I trust, the last winter of this great calamity. Yet despite a dawning hope upon the horizon, individual need in the meantime may be greater than before. Despite these gigantic efforts of direct and indirect relief we must not fail to recognize the slow seepage of the resources of many families and the consequently increased responsibility which falls upon the more fortunate. Moreover there is parallel with it all the depleted resources of those to whom you must appeal for aid. Those who support you this year will many of them be sacrificing from their own needs. No greater call can be made upon American patriotism and self-sacrifice."

"The need before us is immediate. It is large. Millions of men and women face the approach of winter with fear in their hearts. The children sense the dread their elders feel. You have nobly offered your service to them and to the nation. I speak not more to you than to the unseen millions of my fellow countrymen and countrywomen, in personal appeal that they too shall take this neighborly need upon their conscience, that they shall share with you this burden, that they give generously of their means to your support. So out of Charity will come not only Hope but Faith."

Newton D. Baker, Chairman of the National Citizens Committee:

"When we come to so great a crisis as the one the country now faces, the lessons thus learned on a smaller scale seem all the more important, and my associates on the committee and I have a deep conviction that we must not let the size of the mere relief needs in the present emergency lead us to forget that relief to be wholesome and helpful must be accompanied by the kind of personal interest which, under the name of welfare or character building work, has become inseparable from relief work in normal times." . . . . "We must all be very much concerned to preserve the wholesomeness and self-reliance and civic virtue of our adult unemployed who this winter, for the first time in their lives, must see themselves and their families partially or wholly charges upon the bounty of their fellows."

"As the standard of living has risen and the scale of our civilization has ascended, it has become increasingly and more imperatively true that 'life is more than meat and the body more than raiment.'

"It is in this spirit that our committee hopes to challenge the conscience and good will of the country. The provisions already made by Congress and state governmental agencies are helpful and indicate the sort of official community conscience and responsibility which is reassuring to people suffering from unaccustomed and undeserved want. But these are not enough. To all these public recognitions there must be added a devotion of every private resource both to extend the funds purely for relief and to preserve and intensify the curative ministrations of welfare and character building agencies which are more critically needed now than at any other time."

C. M. Bookman, Executive Secretary, Cincinnati Community Chest:

"The social agencies in practically all our cities have formed a partnership of effort, both in securing money and in meeting the social needs. This partnership is known as the 'Community Chest.'"

"More money than we even now contemplate will be required to meet the direct relief needs during the coming winter. It will take the entire amount appropriated by Congress, definite financial assistance by the states and local governmental units, and the maximum of private giving, if we are to come through next winter as satisfactorily as we came through last winter. Not enough money will be available to do the job in a wholly satisfactory way. Relief needs are easily dramatized for direct contact with those needing relief has been experienced by all. The need for other services is not so clearly understood and should receive particular attention. Specific and definite illustrations drawn from the experiences of social workers and social agencies must be used. Not only food, clothing, and shelter must be provided, but health safeguarded, children protected, family life and morale preserved, the young people given a chance. All this is necessary if the emergency is to be met." . . . . "The battle lines are drawn. These conditions call for a complete mobilization of the resources of the nation. The part the federal government is to take has been determined by Congress. In setting our campaign goals we have leaned heavily upon local and state tax support. The part asked from private sources is merely to supplement tax support. The simple statement of fact is, that all available tax support is needed and the contributions of corporations, business concerns, and individuals are required if real suffering is to be averted this coming winter, and if a staggering price is not to be paid in the future for our failure to meet the present issue. Business organizations, as such, should give as business has found it necessary to throw upon taxation and private philanthropy a large per cent of its employees. These men and women contributed their strength to building up the capital assets of the nation. They are now public charges. They are also our fellow citizens and our future working force."

"We should like to see in addition to the Committee represented here today, the women of the nation organized into a national crusade, under competent leadership with a strong committee of women in each community. Women are especially fitted to understand and appreciate the needs that must be financed this year. Women did not hesitate to give their time during the war to any service that would contribute to victory. They have just as great a stake in the success of this effort as in any ever presented to them. They will rise to the occasion if they know the need for real sacrifice. They can organize a crusade against indifference, selfishness and fear. They can stress the absolute necessity of meeting present social needs so that families will not disintegrate, that health may be preserved, that the children of the nation may have the opportunities that childhood in the lowliest circumstances requires and is entitled to."

Louis F. Kirstein, Vice-President, William Filene's Sons Company, and President, Associated Jewish Philanthropies, Boston:

"It is my firm conviction that the general spirit we bring to the conduct of our coming campaigns will prove much more important than details of strategy; or, perhaps I should say, that our spirit will constitute the most important element in our strategy. There must be fire in our eyes; and fight in our hearts! We must strike out with firmness and conviction—to break down the apathy, the resistance, and the defeatist attitude which prevails in certain circles in our respective communities.

"Heaven only knows how many millions of self-respecting citizens will be dependent upon our social agencies during the coming winter! There seems little doubt but that the number will constitute the largest in our history. . . . . Relief funds contain our guarantee against the basic miseries that breed hunger and disease; what I may call morale-funds contain our guarantee against the demoralization that breeds lawlessness, disloyalty, perhaps angry revolt and upheaval. . . . . We must make contributors realize that it is not only the actual poverty, not only the insecurity of income consequent upon unemployment, but also its discouragements, its demoralization, its sense of not being needed, that destroys people, saps character and creates such great suffering and anguish. We must make them, too, see what is so obvious to us who are close to the scene—that hospitals, settlements, child-caring agencies, camps, social case-work are more necessary today than ever before during our lifetime. Yes, and we must make our contributors realize that, to do this difficult and complicated job well, and to assure the most efficient expenditure of whatever funds we raise, we must keep intact our skilled, professional, social work staff."

"To deny a man, able and anxious to work, the right to work, is after all a fundamental wrong and evidence of a basic defect in our social and industrial organization. There is heartening evidence in a number of directions that its challenge will not go unheeded."

How New York City Handles an Epidemic

Infantile Paralysis

By ALICE A. FITZGERALD, R.N.

JULY, 1931, with its hot days brought to New York the dread scourge of infantile paralysis. Each day the number of cases crept up. Wary nurses and doctors recognized the fact that, should the numbers hold, an epidemic was on the way.

The first week of August our fears were realized; cases were increasing daily. After a consultation with the Commissioner of Health, and other agencies working with crippled children, a meeting was called by the Children's Welfare Federation. Workers from the city hospitals who were caring for the children during the acute stages, and workers from the nursing organizations who would give after-care in its varied branches were brought together and the situation was discussed from all angles. It was suggested that the Federation conduct a clearing house for all cases and so prevent unnecessary visiting, at the same time insuring after-care for each individual case. Everyone present agreed that a clearing house would be invaluable.

STARTING THE CLEARING HOUSE

The Department of Health's daily contagious lists were obtained from the first day of 1931 and all infantile paralysis cases copied on cards. The cards were filed according to the streets within the five boroughs of New York City. This file was called the control file and was augmented daily from the Department of Health lists as they came through.

Due to the urgency and number of cases, the very simplest form of clearing was evolved. All cases reported to the Department of Health were sent to the Children's Welfare Federation on slips provided for the purpose; each slip stating whether or not the child was under the care of a private physician or hospitalized. In response to a letter outlining the plan for clearing cases and providing after-care, forty-two hospitals reported the discharge of their patients. These slips, upon being received in the clearing house, were cleared through the control file and sent on to the nursing agency working in the field nearest to the child's home. In this manner, each case was sent to an association which would handle the after-care of the patient. In sections of the city where no organized orthopedic after-care was provided through a nursing association, the other visiting nurse associations undertook to visit patients to see that parents knew where to go for clinic facilities, if the case was not under the care of a private physician. The Federation compiled a list of orthopedic clinics throughout the city, giving detailed information as to hours, visiting days, etc., which was distributed to the nurses. Six nursing associations assumed the responsibility of after-care, thus covering the entire city.

THE AFTER-CHECK

When the epidemic had run its course, all cases remaining in the control file were listed and referred to the agencies in the respective boroughs. There they were checked to make sure that not one case had been passed by.

The results have proved very interesting and valuable as an experiment in community organization in an emergency. *The coöperation of all agencies was complete,* each case being visited by tireless nurses working overtime in the heat of summer, giving expert advice to helpless and bewildered mothers. In cases where the paralysis had cleared, visits were made at the end of three months to make sure that no muscle weakness had developed.

Without a central clearing bureau the

hospitals would have had difficulty in providing after-care for every case and no doubt many cases would have fallen between two agencies, which often happens when a case is referred to the wrong agency. A typical case that was cleared through a series of agencies was that of Rose Brown:

1. The Department of Health reported that Rose had been admitted to a hospital for contagious diseases. 2. The hospital discharged her to an orthopedic hospital. 3. The orthopedic hospital discharged her. 4. After-care agency was notified of all transfers. It can be seen how easily Rose could have been lost in transfer, if not carefully followed through.

The accompanying table was compiled from reports sent in to the clearing house by the after-care agencies, May 1, 1932. The reports show what happened to the cases, how many duplicate clearings occurred, the number not located, those under other care, such as hospital, private physician or convalescent home, as well as the number of dead, and dropped as "no case" or incorrect diagnosis. The number of cases with residual paralysis is undoubtedly the most pertinent figure in the chart, showing that the highest percentage of these cases strangely enough was in Manhattan, a borough which had a lower incidence of the disease than Brooklyn.

REPORTS SUBMITTED TO THE CLEARING HOUSE BY SIX NURSING ORGANIZATIONS MAY 1, 1932

	Manhattan	Bronx	Brooklyn	Queens	Richmond	Out of Town	Total New York City
Total number of clearings of cases referred to clearing house	1079	978	2894	948	264	27	6190
Duplicate clearings of cases	243	333	532	431	120	....	1659
Not located	60	49	....	81	4	....	194
Under other care, hospital, etc.	45	28	322	34	7	27	463
Dead	102	82	*237	25	14	....	460
Dropped (no case)	37	6	99	17	3	....	162
Total	—487	—498	—1190	—588	—148	—27	—2938
Total cases given after-care	592	480	*1704	360	116	0	3252

CONDITION OF AFTER-CARE CASES—JUNE, 1932

Residual paralysis	402	251	1056	143	60	....	1912
No paralysis	190	229	648	217	56	....	1340
Total	592	480	1704	360	116	—	3252
Per cent of residual paralysis	68%	52%	62%	40%	52%		59%

**Figures given cover a section of Queens as well as Brooklyn.*

CHEF'S ERROR

A public health nurse upon reaching a little city, went to a restaurant to get a bite to eat. The waiter asked her what she would like to drink. Thinking always in terms of public health, she looked around for the placard which would advertise the kind of milk served there. Not seeing one, she asked, "Do you have a milk ordinance here?"

The waiter looked puzzled, went back to the kitchen, returned shortly and said, "Lady, we just don't have that on the menu today."

Developing Community Responsibility

By EDNA L. HAMILTON, R.N.

THE public health nursing program of the Children's Fund of Michigan is conducted on a county-wide basis in the more remote and rural areas of Michigan.

The program is concerned primarily with the promotion of health for all children of the community which it serves. The Children's Fund does not duplicate or take over any service, but seeks to establish a public health nursing program where such a service does not exist and, in most cases, never has existed. It is one of the expectations of the Fund that the services will be enlarged or taken over entirely by the county when the child health program has proved that it is no longer an experiment, and when the county is financially able to do so.

Because child health concerns every parent and citizen of the county receiving the services of the Children's Fund nurse, it is felt that a committee of responsible and representative citizens interested in the welfare of children is necessary to insure the permanence of the program. Furthermore, with such a committee, it is possible to secure very quickly a rather complete understanding of the program and a greater dissemination of the aims of its various phases among other people of the county.

THE COUNTY COMMITTEE

The entire child health program is based upon education, since it is only through education that lasting improvement in civic conditions may be brought about. With the nurse as the professional leader, the committee discusses general problems of child health as well as local problems, and draws up a plan for their solution. In this process the group educates the nurse, and is in turn educated by her.

The objectives of the committee are:

To educate the citizens of the county regarding the public health program.

To interpret the particular needs of the community to the nurse, to public and private agencies, and to the community at large.

To participate with the nurse in formulating a program of child health and welfare suited to the needs of the children in the county.

To take an active part in solving any problems which pertain to child health.

To organize subcommittees to meet various needs, such as publicity, program, transportation, infant and preschool clinics or conferences, maternity and infancy supplies, immunization, social service, May Day, Loan Fund, and for dental, eye, tuberculosis or crippled children clinics.

QUALIFICATIONS FOR MEMBERS OF THE COMMITTEE

The members of the County Child Health Committee are chosen because they have certain qualifications which will assure their interest in child health, and a successful child health program. The qualified member should have:

Leadership in his own community, and the county at large.

An expressed interest in child welfare and in public health.

Special experience and education that fit him to contribute to the improvement of civic conditions.

The ability to work with other people.

County-wide vision.

Time for study and promotion of the child health programs.

The officers should represent different sections of the county and consist of a chairman, a first vice-chairman, township chairmen, a secretary, and an assistant secretary or treasurer. The first vice-chairman should be one who can act in the absence of the chairman, and should be appointed with the thought that he may later become chairman. It is well to select the officers from various townships or rural centers. The township chairmen represent the township committees. These officers constitute the executive committee of the County Child Health Committee. It is advisable to have the officers of the county committee chosen from the lay members

with the professional members of the committee acting in an advisory capacity.

The membership of our county committee consists of one or more representatives from each of the following groups: school authorities, board of supervisors, churches, clubs and other groups, and of individual members such as doctors, dentists, the judge of probate, the poor commissioner, the agricultural agent, and the editors or other representatives of the press. The clubs referred to may be: Ladies' Aid, W.C.T.U., Woman's Club, King's Daughters, Parent Teacher Association, Kiwanis, Rotary, Lions, Grange, Farm Bureau, Chamber of Commerce, and Red Cross Chapter. The public health nurse of the county is an ex-officio member of the county committee and its subcommittees.

The accompanying chart shows the organization of a typical county child health committee developed under the Children's Fund.

TOWNSHIP ORGANIZATION

Each township should have a subcommittee patterned after the plan for the general committee. Members of the township committee include a representative from each school district and the local supervisor. All local people interested are members at large of the township group. Through the membership of the chairman of the township committee on the county committee, the needs and problems of the smaller unit are presented. Information regarding the proceedings of the county committee is carried back to the local group through the township chairman.

USE OF SUBCOMMITTEES

In order to carry out the objectives of the child health committee as outlined, it is necessary to appoint subcommittees of both the county and the township groups. These are standing committees appointed each year at the annual meeting. The suggested subcommittees are: Publicity, Program, Transportation, Infant and Preschool, Maternity and Infancy Supplies, Immunization, Social Service, May Day, Loan Fund, and Clinic.

It has been found that for the purpose of good organization each subcommittee should be made up of a chairman who is an officer of the county committee, and of representatives from the different township committees. The township representatives may then form township subcommittees as needed. On the township subcommittee the chairman should have members from other local organizations or groups who are known to be especially interested in the activity to be promoted.

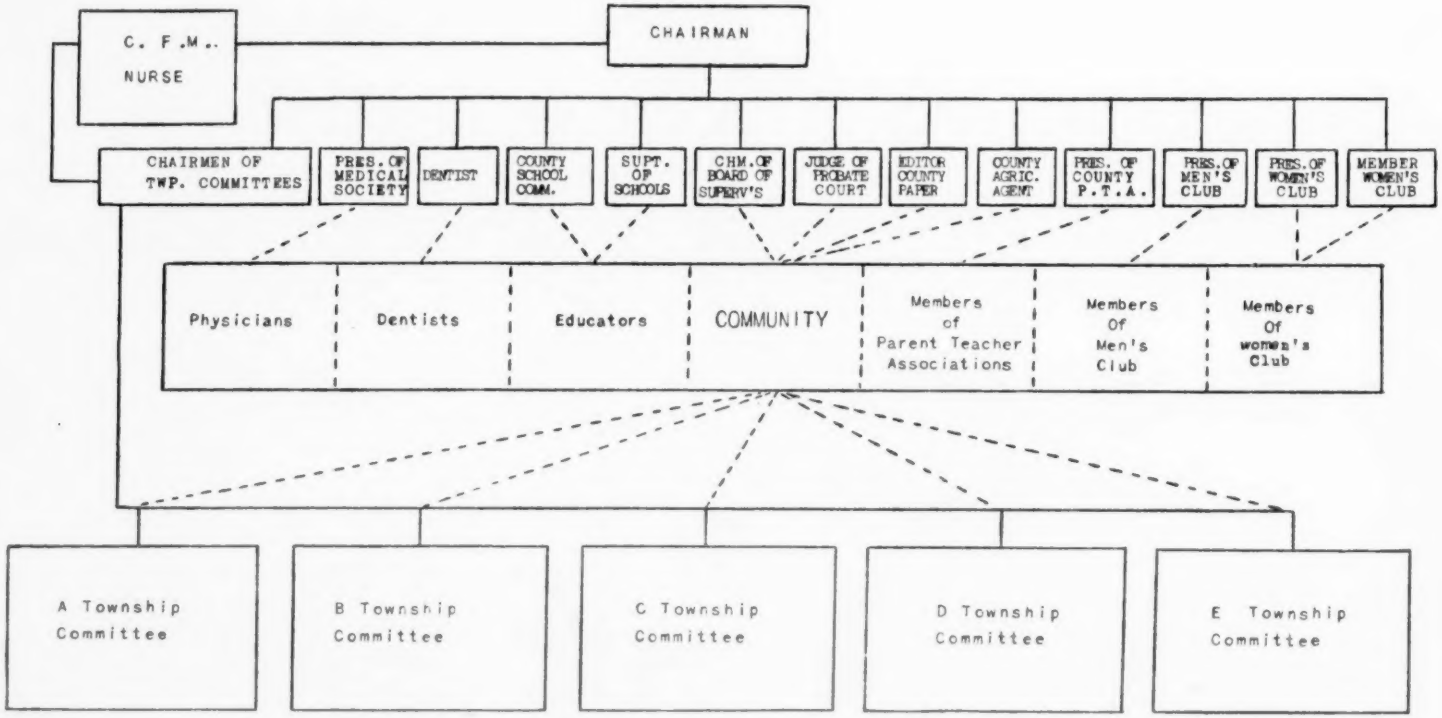
DUTIES OF SUBCOMMITTEES

The duties of the subcommittees are many and varied. The *Publicity Committee* is responsible for the articles in the newspapers regarding the County Child Health Committee activities, or other items pertaining to the health and welfare of children. Such articles may be prepared by the committee members and the nurse, and published weekly in a column set aside for that purpose. This committee aids the program materially by interpreting it to physicians, dentists, public officials, neighbors and friends. For instance, one county is fortunate enough to have three ministers, representing as many denominations, who are strong supporters of the child health movement and feel it to be of such importance that they make special announcements from their pulpits. They call the attention of their parishioners to immunization campaigns, dental clinics, May Day celebrations or other child health activities. Thus these three men are valuable members of the Publicity Committee.

The *Program Committee* is responsible for the program of each meeting, and for special programs throughout the year.

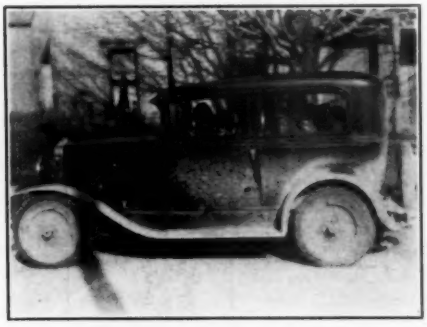
The *Transportation Committee,* as its name implies, provides for the transportation of children to clinics, to the physicians' offices, and to special meetings such as the May Day celebrations. In some cases the committee makes arrangements for the school bus to handle such transportation; in others, privately

ORGANIZATION OF TYPICAL COUNTY CHILD HEALTH COMMITTEE



owned automobiles are called into service. It is deemed unwise for the public health nurse to take time away from the many professional duties for which she has been engaged to transport children. This is a service which citizens with cars will gladly render if they realize the need.

The *Infant and Preschool Committee* is responsible for summer round-ups, baby and preschool conferences, and mothers' classes. It makes all arrangements as to the time and place of the conferences and classes, choosing a place centrally located, and a time most convenient for the majority of the mothers. Members of this committee also provide volunteer helpers to assist at the conferences by taking histories, weighing and measuring children, and providing amusement for small children. In addition, the Infant and Preschool Committee has the duty of reporting to the nurse all expectant mothers, new-born infants, and preschool children in their districts.



A Carload for Clinic—Volunteer Service

The *Maternity and Infancy Supply Committee* renders a valuable service to the county by making and distributing baby layettes and sterile maternity kits. These are furnished either free of charge or at cost to expectant mothers. In many instances physicians are also supplied with maternity kits. In one county in which the infant mortality rate was very high, the nurse aroused the interest of the local people in this problem. She met with a group of women who had had at one time an active club. She interested this group in making layettes and maternity kits, and these women in turn interested other groups so that within six months' time one hundred and fifteen women in different sections of the county had formed into five Maternity and Infancy Supply Clubs. The maternity kits are sterilized by a local hospital free of charge. A physician who recently moved to this county has found this group of value to him in furnishing sterile supplies for his obstetrical cases, and he is reimbursing the women for the material.

The *Immunization Committee* has the responsibility of organizing campaigns for immunization against diphtheria and vaccination against smallpox. Members of this group engage the physician, arrange for the funds, secure the room with the necessary equipment for giving the treatment, and provide the helpers needed to assist the physician and the nurse. The helpers collect the consent slips, keep the children in orderly lines, prepare the arms for treatments, and otherwise assist in conserving the time of the physician and the nurse.

The *Social Service Committee* renders a valuable service to the public health nurse. Needless to say, it should be made up of those citizens who are socially minded. The duties of this committee may include friendly visiting; the collection, making over, and distribution of clothing; the establishment of a loan closet; and the provision of cod liver oil and milk to undernourished children. An instance of social service need was reported by a nurse:

> A mother had died leaving a family of seven children, the eldest a girl of fourteen. The father was a hard-working laborer who made good wages and provided well for his family, and wished to keep them together. Neither he nor his daughter knew anything about good housekeeping or home making. This case was reported to the Social Service Committee. A member and a friend called on the family; found the girl a willing pupil, and the other children anxious to do their share. She assigned each child a daily task, taught the fourteen-year-old girl how to buy food and clothing for the family, and how to manage the home in an efficient way. The

father was encouraged in his efforts and after a few weeks the home showed a marked improvement.

The *May Day Committee* should be appointed in the fall to give time to prepare during the school year for the May Day celebration sponsored by the County Child Health Committee. In addition to making plans for the program, members of the committee arrange the time and the place of the celebration, and secure the necessary publicity.

The *Loan Fund Committee* should be responsible for the distribution and collection of any Loan Fund moneys.

The *Clinic Committee* has many responsibilities, which include: collecting lists of children needing treatment and deciding on those who should receive free care; arranging for the time and the place for clinics, providing for proper office space with heat, lighting, and water facilities; arranging for transportation when necessary; making home visits to parents of children needing eye, dental or other treatment; explaining the service and obtaining the consent cards; follow-up visits to encourage the child in wearing glasses, or in carrying out instructions given by other clinic physicians; delivering appointment cards for eye or dental clinics, and arranging for local children to be available in case an appointment is broken by a rural child.

PLANNING THE COMMITTEE MEETING

Meetings should be held regularly at a time convenient for the largest number of the group. A night meeting might be held two or three times a year so that teachers or busy husbands could be present. A Saturday afternoon picnic once a year for all the families of the County Committee members tends to promote a friendly relationship between the people of the various townships, many of whom do not have an opportunity to meet people from other parts of the county, because of poor roads in the winter and spring, or other difficulties of transportation. Even the baby may enjoy the outdoor picnic from its own clothes basket bed! (See accompanying picture.)

Baby joins the annual picnic of the County Committees

It is a good plan to have the meetings rotate from one section to another so that every district or township in the county has the advantage of direct contact with the members of the committee.

The program should be planned well in advance, in order that those participating may have time to prepare their papers, reports, or other contributions. It is well for the chairman of the County Child Health Committee, the Program Committee, and the nurse, to meet to-

gether to plan a program for at least six months in advance. A simple and inexpensive way to have programs to distribute is to mimeograph them on white or colored paper.

Local people may have real contributions to make to the programs. The local physician may be called upon to speak on preventive health measures or the local dentist to discuss dental care and its importance to the growing child.

Too far to walk to the dentist—A friendly neighbor offers a lift

Children and teachers can make speeches, or give playlets and demonstrations of first aid or other health activities. Often a local person of prominence will respond to an invitation to speak of some special health or civic measure with which he may be conversant.

Outside speakers, either state or national, may often be secured, especially, when invited far enough ahead to plan for the visit as a part of a trip in their regular line of work. The state agricultural college or special schools for the handicapped may have a worker who could talk on some special phase of health promotion. Delegates from the committee may be sent to visit state institutions and report back to the committee. Such a report is doubly interesting when a child from the county is a patient in the institution visited. Trips to dairies in a county or to a pasteurization plant in a nearby county are of great educational value. Other committee members may make trips to sources of water supply, also to state meetings such as those of the Public Health Association or the Parent-Teacher Association.

A tentative program for eleven months may be planned in advance. The outline of a typical eleven months' program follows:

September—Nursing program in the schools for the coming year: Nurse
Demonstrations: (Children participating)
Vision and hearing tests
First Aid
Other
Material on display: School health records
Demonstration material
Special Guests: School officials and teachers

October—School Sanitation and Ventilation: Sanitary Inspector
Material on display: Playground equipment
Discussion for May Day plans next spring; committee to be appointed
Special Guests: School Directors

November—Report given of committees appointed for May Day, 1933
Communicable Disease Control: County Health Officer or other public-health-minded physician
Special Guests: Supervisors and local health officers

December—Loan Closet
Welfare committees
Christmas cheer to those in need

January—Reports on Loan Closet and social service activities such as clothing collected and distributed, home visits, etc.
Special Guests: Representatives from groups that are coöperating with the relief program, *i. e.*, Red Cross, Ladies' Aid, County Welfare

February—Definite reports on plans for May Day. Other reports or needs for special activities

March—Final arrangements for May Day: time, place, program
Final township committee reports for the eleven months including March (these to be given to the nurse for her annual report to the home office)

April—Final reports for May Day
Discussion of ways and means for the clinics to be held in the county during the summer months

May—Report of the May Day celebration
Plans for crippled children's clinic
Transportation and clinic help

June—Plans for eye clinic
Summer dental program—final reports

July—Plans for preschool clinics to be held in August
Transportation and clinic help

August—Picnic

The workers of one community or township need to know what other townships are doing. It is essential therefore that the first part of every program, following the reading of the minutes, should consist of the reports from each township chairman of the work in her township since the previous meeting and of a report from the nurse of her activities for the past month. The nurse should also have the opportunity to discuss any matter pertaining to her work such as the coming of new activities into the field.

Infant and Preschool Clinic. A Health Committee member takes histories

GETTING RESULTS

To illustrate the value of township committee reports, I am citing a few instances given at one of our county meetings. This county has fourteen townships, of which twelve are distinctly rural, of poor land valuation, and more or less isolated:

One township chairman reported that her school district was so poor that she deemed it unwise to insist that they provide paper towels, so she sent away for one hundred flour sacks, and she and her local committee members made them up into eighteen-inch hand towels for the children in the rural school. Each child took his towel home at night and returned to school with a clean one each morning.

This same chairman and her group were also instrumental in arousing the interest of the boys in making shoe scrapers, both for their homes and school. One school had a muddy yard and needed a foot scraper, but the school board would not provide one. The husband of a committee member made one out of two birch tree posts three feet long, and a two-foot piece of iron. The posts were sharpened and pounded into the ground two feet apart so that they projected about six inches above and two inches from the lower step. Deep notches were cut in the top of each post and the iron hammered into them. The scraper was placed near enough to the step for the smallest child to reach it but far enough away so that the mud scraped from the shoes would fall on the ground.

A township committee aided the teacher by encouraging clean-up days as well as other health activities in the school. One boy used nails to make holes in the lid of a mustard jar to take the place of the oil can suggested for the handwashing procedure. The school was too far away from a hardware store or a gasoline station to buy one.

A township chairman reported that there was only one car in her township, a 1916 Model T Ford which would run if fed with oil and gasoline, which its owner, a widow with five children to support, could not provide. The township committee took up a collection of nickels, dimes, and pennies from

the families with children needing dental care, and with this the owner of the car bought gas and transported sixty-six children of the district to the dentist twenty miles away.

Another chairman said that nothing had ever been done about the outside toilets since they were built a number of years ago. Members of the township committee called the attention of their husbands to the unsanitary conditions prevalent, and they not only cleaned the toilets but became so interested that they painted the building outside and whitewashed it inside. Then they discovered there was no water on the premises, and proceeded to have a driven well put in.

In one community the parents were not interested in hot lunches, and the committee member from the school district could not get the school board to provide the equipment or to fix the top of the jacketed stove to hold the pan of hot water for the hot jar method. The teacher tried to interest the children but failed. One day she brought a small jar of vegetables. She set it in a small pan of water on the ledge of the stove at recess, and at noon ate her hot dish. The children gathered around her while she ate but she said nothing. Soon one child brought a jar, then another, until the pan was not large enough to hold all the jars brought. Finally a parent came, examined the stove and made an adjustment for a large pan on top. In a short time the hot jar method for noon lunch was an established procedure in that school.

Many other instances like these could be given, showing the part the committees play in making the health service available to children in isolated areas. As the service is confined to rural areas which for the most part are sparsely settled and the settlements far apart, some means must be found to help the nurse and to make the needed services available to the greatest number. Through the leadership and experience of a well educated nurse, especially prepared for public health nursing in the county, and the carefully directed activities of an organized county child health committee, we are finding that many problems of rural public health nursing may be met and overcome, and we believe we are building a sound foundation for permanent interest in health throughout these rural counties.

ANNUAL RED CROSS ROLL CALL

The annual Red Cross Roll Call starts Armistice Day and runs through Thanksgiving. Last year (July 1, 1931 to June 30, 1932) the sum of $6,506,500 was expended on the following services by the National Red Cross:

Disaster Relief
Health Activities:
- Enrolled Nurses Reserve
- First Aid and Life Saving
- Home Hygiene and Care of the Sick
- Nutrition
- Public Health Nursing
- Other Health Work

Junior Red Cross
War Services:
- To Disabled Veterans
- To Men now serving in the Regular Army and Navy

Other Domestic Activities
Insular and Foreign Operations
Supervision and General Management

In addition, the 3,500 chapters of the Red Cross expended approximately $7,500,000 during the year.

This year the Red Cross needs your help as never before. James L. Fieser, Vice-Chairman in charge of Domestic Operations, writes in the Red Cross *Courier:*

"For half a century the Red Cross has slowly, surely, and progressively forged the links of the chain of helpfulness. Without the voluntary contributions of work and funds from our warm-hearted people that chain could not have been forged to its present unbreakable strength—a strength that has resisted and persisted to the end that the Red Cross shall forever carry out the people's will to succor the wounded in the struggles of peace as well as of war. . . . The necessities of the times justify a supreme effort and no compromise this year. A 'no man's land' in membership and humanitarian service does not exist."

Have You "Sold" Your Board?

By VIOLET H. HODGSON, R.N.
Assistant Director, National Organization for Public Health Nursing

THE immediate future of your public health nursing program will be determined in large measure by the answer to this question. If the director of a nursing service (one nurse or multiple nurses) can answer, unqualifiedly, in the affirmative, there is little possibility that this community activity will suffer disproportionately during the present situation, or the period of readjustment to follow.

In answering this question one cannot be content to say "yes" or "no" on the basis of attendance at board meetings, or the interest of individual board members in the activities of the organization alone. It must be decided on the broader basis of general community interest and participation. For, in the last analysis, this community health consciousness should be a major purpose and objective of a lay administrative or advisory group. Public health nursing truly becomes a community service when it serves the needs and secures the support of the entire community. And just as the nurse arrives at this goal, in a measure, through her ministrations to the individual and family, so too the board shares in hastening the integrating process by helping to bring about a united and intelligent support of the program by the community.

Public health nursing is not a "charity." It is a sound and profitable investment. Like other health work, it is one of the few investments which has continued to pay returns when many of our heretofore "gilt-edged" securities have either reduced or discontinued their dividends. Indeed, the health of this country is its one brightest aspect at this moment. There is no gainsaying that public health nursing has helped to build this wealth of resources in community health. The support of this service should therefore come from the community served and be an integral part of the economic planning for that community. It is generally recognized that public health nursing cannot afford to be an isolated project either in terms of service or financial support, and it is in this integrating process that the board assumes a strategic position. In order to function intelligently and effectively in this capacity, the board must not only be familiar with the health needs of the community and the social agencies set up to fill them, but it must be equally familiar with the activities of its own organization and their obvious or potential contributions to the welfare of the community. It is here that the director of the nursing service will find the answer to our original question. "Selling" the board is transferring the enthusiasm and convictions of the professional group as to the value of the service to the lay group, through interpretation of the program and its relation to community health. "How can the nurse make this transfer" is another way of saying how can you "sell your board." A few ways are reviewed briefly here.

WHAT KIND OF A BOARD

The individual and group method of approach are as applicable in the relationship of the nurse to the board, as of the nurse to the community or of the director to her staff. Each approach has its advantages in special situations, but it is the board as a whole with which we are concerned at the moment, and therefore only the group contact or board meeting will be considered.

Before being committed to the premise that "as the board goes, so goes the community," it must be assumed that the board is representative of the community and that it presents a true picture of all the social, civic, religious, and regional interests of that community. As a community service it devolves upon the public health nursing agency to extend its services to all

groups. To do this most satisfactorily, it is just as necessary for the nursing agency to acquire an intelligent understanding of the needs and viewpoints of these representative community groups as it is to share with them the purposes and goals of the nursing service. The board, if widely representative of these groups, is an admirable device for this interchange and coördination and strengthening of community interests.

In developing a method of sharing organization activities with the board, it is well to keep in mind the distance that may exist between the board and the work of the nurse in the field. No longer, as in the early days, is it possible for the board member to know cases through personal contact in their homes. To bridge this gap, an intimate anonymous picture of significant community situations may be given by the nurse.

Competition of interests is another challenge facing the nurse in securing a fair share of the efforts of board members in public health nursing service. Many other demands are made upon their time, both in the home and the community, and competition is more likely to be successful if the work of the organization is made vital and essential to their individual problems at home, as well as those more general to the community. As fathers and mothers, the entire public health nursing program assumes great import from the prenatal period through the entire school health period. As leaders of industry and commerce, the care of the sick or injured worker will be quickly translated into the assets thus derived from a program of good management.

And then, let us remember how unintelligible some of our everyday terms may be to members of the board, particularly the new members. Morbidity, ante and postpartum, Mantoux test, generalized service, clearing with the social service exchange, and many others which have become commonplace to the nurse through usage, may have little meaning to the board unless clearly and interestingly defined.

HOW TO TELL THE BOARD

One of the surest ways of producing a moribund state in a board is to feed it a diet of statistics. Figures have their place in any well run business, but, like other unbalanced diets, they will ultimately cause undernourishment in some part of the organism, and, in the case of a board, this is likely to affect the most vital part of its make-up, viz., its interest. On the other hand, statistics can be made "vital" through the addition of a little human interest relating to matters of organization and community import.

Take the item of visits, the old standby of all reports, as an example of this vitalizing process. "Thousands of visits" are impressive just as thousands of most things, even dollars these days, are attention-arresting. Usually, however, this interest is fleeting and the board adjourns without taking away one impression unless the nurse has added that this number is in excess of last month's visits! If, however, to number is added some explanatory statement such as an increase in bedside care, the number of pneumonia cases accounting for this increase, and the number of families in which the nurse was able to teach a member of the family to give adequate care in her absence, and the number of cases in which this care may have contributed to a shortening of the convalescent period, and the number in which a history of tuberculosis was disclosed and for whom preventive follow-up care has been secured, and if, perchance, to the foregoing could be added an estimate of the probable financial saving to the family and community of home care as against hospitalization, or the prevention of a chronic disease that is both communicable and costly, then figures will become so full of life that they will accompany the board members home and remain with them for some time, certain to reassert themselves at a strategic moment in a P.T.A., Rotary, Woman's Club, Management Association, Chamber of Commerce, Ladies' Aid, Y.W.C.A., or other meeting.

INTERPRETING CASES AND PROGRAM

Examples of the money-saving value of the service can be found in the care

of the pneumonia or tuberculosis case in the home. It is quite simple to compare the cost of this care with that of hospitalization (always assuming, of course, that the latter has not been recommended) by comparing the combined items of the cost of the physician's and nurse's visits and medication with the hospital rate for a corresponding period. This, of course, does not take into consideration the item of food, which is included in the hospital charges, but which is almost negligible when considered as part of the family food allowance. The comparison of these two types of care for the tuberculous can be made particularly striking because the disease is of such long duration, and its chronicity makes close supervision by the physician less necessary than in acute conditions, such as pneumonia, thereby still further reducing the cost of care in the home.

Or again, if the organization is a widely "generalized" one, follow up visits to school children or industrial workers might very effectively be translated into the reduction of time lost from school or work and its ultimate saving in dollars and cents to the community in school taxes, to the industry in uninterrupted production with its costly adjustments, and to the worker in wages earned.

If such an analysis—interpreting the service—can be made by the use of the total visit figure, the ease with which the statistical report on special activities (prenatal, postpartum, infant hygiene, communicable disease, etc.) can be utilized in visualizing public health nursing as an individual, family, and community service must be obvious.

Quality of Service: Although deviating somewhat from our heretofore classical use of "visits" as a means of impressing the board with the growth of the nursing service, it must be said that an attempt to *reduce* the number of visits is not an unworthy objective, and has tremendous "selling" qualities in these days of retrenchment.

If greater effort were made to improve the quality of the service, it is conceivable that a considerable saving of money to the organization and community would result from a reduction of quantity. One is sometimes tormented with the thought, when hearing a report of increasing numbers of such and such visits, that perhaps even nursing has been infected with the slogan of mass production. It is a kind of mass production, to be sure, at which we are aiming and at which we have arrived with no small measure of success as indicated in the lowered morbidity and mortality rates, but one sometimes wonders if the time has not arrived when we can still hold and even increase our present health status through a better quality of service accompanied by a reduction in quantity. More attention to planning the content of the visit, weighing its relative importance, and greater emphasis on the technique of sharing health information with the individual and family might well deserve a more prominent place in our future objectives. To the board, this would mean supplementing the statistical statement indicating a decrease in visits by an analysis of the improved quality of the service as noted in the content of the nursing visit as shown on the record. If, for example, it can be shown that a nurse has been able to secure the same results in teaching the value of toxoid treatment in two visits, where formerly the number averaged four or five, under as nearly similar conditions as pertain in families, a saving of community money equal to the cost of the difference in numbers of nursing visits is at once apparent. Furthermore, it can be shown that the end results are the same in that the child in each case was immunized against diphtheria. Equally interesting and significant to the board is this tangible evidence of improvement in the teaching ability of the nurse herself.

Numbers of toxoid treatments and vaccinations are other examples of dull figures, if unaccompanied by an interpretation of their significance. How potentially vital and dramatic, however, if what they really prevent can be described—that loathsome pest, smallpox, and that terrifying disease, "black diphtheria," which are almost like fiction to

many board members today insofar as actual contact with them is concerned.

The Well-Baby Conference: And what of the attendance at well-baby conferences? Is it merely a matter of numbers, accounted for on the basis of sunshine or rain, or do they return perhaps as children to school who are eager to learn and recite the lesson learned on a previous visit? Can this activity also be translated for the board in terms of saving of community money through reduction of nursing visits otherwise necessary? Have some of the board members assisted at these clinics and thereby obtained first hand knowledge of the program? Are new preventive measures inaugurated by the physician explained in terms of their value to the family and community? Is each step of the conference so well understood in relation to the baby, the family, and the community that every board member could make a fifteen-minute "sales" talk on this activity at a Woman's Club or Chamber of Commerce meeting?

Case-Finding: And then there is the case-finding program, so full of interesting material for the board! Do you analyze your nursing records in each service with a view to measuring your contribution to the early discovery of disease through recognition of symptoms of physical, mental, and emotional maladjustment, and appropriate steps taken in securing their correction, or retarding the destructive process? If so, does your report to the board include not only numbers of suspicious conditions found and individuals referred to private physicians or clinics for treatment, but are these activities made thought-provoking by relating them to the social and economic problems that *might* result if preventive measures were not instituted? One cannot say with finality that advising medical care for a lump in the breast will prevent cancer. Nevertheless, there is a wide margin of possibility that surgical interference will many times at least retard the development of cancer in its very early stages, thereby prolonging the time during which the economic status of the family can be rendered a little more secure, and the children be enabled to meet the added responsibility because of greater maturity.

Opportunities for case-finding can be one of the most convincing arguments for a generalized program. Its economic aspect, in terms of community saving for the future, although not quite so obvious as that of saving in travel time, etc., is none the less real. Furthermore, the humane aspect of the service should markedly enhance its appeal.

In your school service, are you content to announce the installation of facilities for handwashing, hot lunches, and improvement in the general hygienic habits of the children? If so, an invaluable opportunity has been lost for teaching (and good teaching is synonymous with "selling") the board the basic principles underlying the control of the acute communicable diseases.

Do you simply announce the new program of tuberculin testing among the high school pupils and X-raying positive reactors, without elaborating on the potential contribution of this case-finding measure? Or is this new activity made the subject of your board education program for that meeting in which you share with them the newer knowledge of tuberculosis in which the child plays such an important rôle? Are vision testing and correction of defects just another nursing routine reported or are the results analyzed in terms of better scholarship and improvement in the physical and emotional health of the child? One could go on at great length with similar illustrations of the use of every nursing activity as a means of sharing the organization program with the board, but it must be hoped that the extent of the possibilities is indicated in these examples.

STATE AND NATIONAL HEALTH BAROMETERS

To balance the program of "production and distribution" of the nursing service, the needs of the ultimate consumer should be reckoned with continually. In brief, these needs are indicated in the local, state, and national morbidity and mortality rates. It is not

enough that the board be "sold" to the local service, but their interests should extend beyond their community to the state and the nation, for the conditions that affect health adversely in the country as a whole are bound to be reflected locally at some time. Then, too, without this knowledge of the community it would be exceedingly difficult to balance the nursing program in the sense of shifting emphasis to the greatest need. If the infant mortality rate is low, and the tuberculosis, syphilis, and cancer rates high, it is conceivable that an organization will want to make some shift in emphasis in order to serve the community needs most satisfactorily. Such a shift, no matter how slight, should not take place without *intelligent* action by the board, for it may be necessary to account to the community for the change, and only an understanding of the underlying facts will make a convincing explanation possible. The nurse should see that the board is fully armed with the facts.

If the board is truly "sold" it will mean not only a greater community consciousness and financial support of the service, but a more widespread use of the service. When the board members and their friends call on the public health nurse for those services which do not call for a full-time graduate nurse, and when the private physician utilizes the nursing service to supplement his health teaching program in the homes of the well-to-do, then we can truly say the service has been sold to the community.

One could go on at great length illustrating the above method of interpreting the public health nursing program to the board through committees, use of volunteers, and community organization relations, but, if there is any chance of "selling" the idea, the deal has probably been closed ere this! Further application of the principle of board education can be left to the ingenuity of each individual responsible for public health nursing services.

REPORTS

A State Department of Health defines the nurse's narrative report. It "is a concise statement of the high points of your accomplishments; is an opportunity to humanize on the mere figures of the statistical report; is an opportunity to pass on a successful achievement, coöperative public health project with another agency, and manner of securing public health publicity that achieved a desired goal; is an opportunity to show progress, that can not be measured in terms of figures; is an opportunity to record successful accomplishments of the nursing committee in the interest of public health; is an opportunity to serve your profession by passing on to other public health nurses your methods and achievements; is an opportunity to sell your wares of public health through the medium of public health education."

The narrative report "is not the place to tell about the weather; is not the place to relate your grievances; is not the place for figures unless they are comparative; is not the place to compliment field representatives or department visitors; is not the place to give your plans, unless you are outlining a program that will be applicable; is not the place to relate instances that do not pertain to the public health program, however interesting the story may be; is not the place to air your knowledge of familiar quotations; is not the place to reiterate your routine program; is not the place to chronicle failures."

The Gleaner, Texas.

Health Problems Among California Migrants

By H. EVA BARNES, R.N.

"OH, I know her! She's our Nurse. We had her while we were in cotton."

Black eyes sparkled beneath a mop of uncombed, curly hair, in friendly recognition as the well known "Chevvy" stopped before a row of rather dilapidated-looking tents. While the other children viewed the stranger rather curiously, not unmixed with suspicion, Margarita boldly advanced and jumped upon the running board of the car, exclaiming joyfully:

Cotton camp in winter. Yes, it is water in the center of the picture!

"We didn't think you'd come to peas, too, but we're glad to see you. My little brother Juanito—remember the one that the burn was so bad and you cured him?—well, he's got "hiedra" [poison oak] something awful, his face all swoll up, and yesterday he couldn't hardly open his eyes. Look, Nurse, it's all down by the creek, where we have to get water and wood."

Margarita had migrated with her family along with many others from the cotton fields of the San Joaquin Valley in California, to the section where there are many hundreds of acres of peas, picked by the seasonal labor of men, women and children. The peas last from four to six weeks, and then this "army" moves to the Coast, or farther south for the late peas. After this comes the "cots," then the prunes, followed by grapes, which last until cotton picking time, and thus the cycle is completed. California with its extensive agricultural interests, its great variety of crops, is either harvesting or canning one of these crops every month of the year. The work is done by seasonal laborers who have no settled home but follow the crops from the Imperial Valley to the Oregon line, living in one locality a few weeks or perhaps four or five months.

HOW THEY LIVE

Their homes, if such they can be called, may consist of roughly boarded 10 x 12 shacks on the bare, treeless plains of the cotton belt; or an old tent pitched along the banks of a ravine along which poison oak grows luxuriantly, or a tent is set up in a grove or orchard or under the span of a bridge; the houses may be constructed of paste board cartons, reinforced with old

pieces of tin. The camps vary in size from a few shacks or tents to around 200, housing from fifteen to 800 people.

One room serves as kitchen, bedroom, dining room, and living room. Some families may be allowed to use two cabins if the camp is not overcrowded. Many times a tent is pitched along side a shack and serves as kitchen. Most of the people do not have beds, but a few old quilts or a mattress which can be rolled up in one corner of the room during the day.

The camps are usually located some distance from the highway and are reached by an adobe track over the plains, a narrow ditch bank, or a hard dirt road. On the latter, one can make 40-45 miles an hour in dry weather, but in winter! Then the roads become impassable, even with chains. The adobe soil mixed with a little water becomes the "slipperest mess" imaginable. At times, the car gives a sickening lurch to one side of the road, the engine stops with a dying gasp, and one knows the worst: wheels down to the hub caps in mud, the running board resting on the ground! This may mean a walk of several miles to get a tractor to the rescue.

Picking Peas

CAMP VISITING

In visiting camps one must be prepared for anything. In one place the question, "Is anyone sick in camp today?" brought forth the reply, "Yes, a little girl in the last house."

"Pase," came in soft Spanish in answer to my knock at the door. A small child was lying on an old quilt in one corner of the room. Asked what the trouble was the mother said she was "sick in the leg," and removing a soiled white blanket revealed the entire right hip with a third degree burn. The area was all infected and covered with a piece of white paper. Four days before her clothing had caught fire while putting wood in the stove, and had it not been for the timely assistance of a neighbor she probably would have lost her life. There were smaller first and second degree burns on her back. The family had called no doctor, but had put on some salve which had been used for another ailment some time before!

The father was visited out in the cotton patch. He said he could not afford to have the doctor, there were eight other children and the camp was 14 miles from town. He was finally persuaded to let the nurse take the patient to the doctor.

In another camp, a man came up with the request: "Nurse, a man here has got some 'bumps' all over his face, will you come and see what they are?" From the distribution as well as the history there was little mistaking small

pox! Instructions were left as to isolation and the County Health Department notified.

Driving into the next camp, a mother came hurrying to the car: "My boy, got too much fever, very sick in the throat."

Following her to the cabin, I found a boy about ten years of age, fully dressed, his overcoat and some blankets spread over him. His cheeks were very flushed, his appearance toxic. His throat was almost swollen shut, with white patches visible back of the tonsils. Once more instructions were left with the mother to allow no one to enter the room. At nine that evening the boy was visited again, this time in company with the County health officer. Suspicions were confirmed and the graveness of the situation was explained to the family. Unless he was removed to the County Hospital at once he might not live. The parents understood the danger, but they had no way of taking him to the hospital. There was only one thing to be done, the boy was made as comfortable as possible in the back seat of the Doctor's Ford, and the long 50 mile trip to the hospital started, not knowing whether the boy would live to get there. The hospital was notified to have things in readiness, and the trip was made in safety. In a few days he was out of danger.

HARD TIMES

The winter of 1931-1932 was an extremely hard one for these migrant people. They received very low wages. In the cotton district only 50 cents per hundred pounds was paid for picking, which was but one-third of that received in 1928. This was barely enough to buy groceries during the good weather, when the cotton was good and they could work all day. When the rain and fog began in January, there were weeks when picking was impossible. Never to be forgotten was the picture in one cabin! A girl of five, a boy of three, a baby four months and the young mother and father. There was no flour, the mother was cooking the last of the beans, the baby had no milk for three days, and had been living on a gruel made from flour and water. The store would give no more credit and it was problematical when there would be work again.

Families broke up their make-shift furniture for fuel, there were requests for soap, salt, lard, and clothing. Many children went to school barefooted, and with one thin little coat or sweater. The wind blowing off the snow-clad mountains, is cold and piercing even in "sunny California" and there is many a day when a cold, gray fog blankets everything. The County Welfare Department was appealed to for help while word of the need was published in the newspapers. The response from churches, regardless of creed, as well as social organizations was splendid. Soon trucks filled with the essentials, clothing and

First Aid in Camp

food were brought to a central distributing point, and sent out to the camps.

When the time came to leave the cotton camps the majority of people were unable to go. They had not sufficient money to buy gas, to repair their cars, or to buy their 1932 licenses. Once more the County Welfare Department was appealed to. Gas and spare parts for cars, when absolutely necessary, were given, to allow them to get to other

sections where work was opening up. Arrangements were made with the State Motor Vehicle Department to accept their old license numbers, with the understanding that after they found work, they were to obtain the new ones.

ITINERANT EDUCATION

The education of these children presents a real problem. It is almost like educating a procession. They are in one locality but a short time, and are not in school for the entire term. And there is the language difficulty. They speak Spanish at home. There are several weeks or even months when they are not in school. They are two or three years retarded, which alone makes for difficulty. In many localities the public schools do not welcome them as they come into an already over-crowded school room, and are there but a short time. It is difficult to place them in the proper grade. They may bring in skin diseases which will spread through the entire school. There is interruption to the routine school work and additional teachers may have to be engaged. In California no child can be compelled to go to a school more than two miles away unless transportation is provided. Some camps are placed just outside this two mile limit where there is no means of taking the children to school.

This problem has been solved satisfactorily in the cotton area. The children are usually here for four or five months. In the larger camps migratory schools are established, and in the smaller camps a school is placed in a central place for several camps. These are under the County Board of Education. School starts at 8:00 A.M. and is over at 1:00. Despite the fact that these are one-room, ungraded schools, with inadequate equipment, good work is being done, and for many it is their only schooling throughout the entire year. During the past winter, hot lunches were served, for many came to school without breakfast. During this time, improvement was noted in the school work.

Doing the Household Washing While Mother Picks Cotton

The older children as well as the younger ones, many times, pick cotton in the afternoons. Little girls eight to ten years old will be left in charge of several younger brothers and sisters while the parents work in the field. These "little mothers" may do the washing, bake the tortillas, and see the "frijoles" (beans) are cooked when mother comes home, while keeping an eye on baby brother.

HEALTH PROBLEMS

In this State Mexicans form the majority of this migratory army, with Porto Ricans, and Filipinoes a close

second. In some sections there are gypsies, who are of Roumanian-Serbian descent. There are Americans, a sprinkling of Negroes, and Indians, and a few scattered nationalities.

There is much malnutrition among babies and children alike. Fortunately the majority of mothers are able to nurse their babies, which is one reason why the infant mortality is not higher. The parents are unable to buy fresh fruit, vegetables, or milk for the children particularly in the winter time. A diet of beans, tortillas, coffee, potatoes, and rice is not the best in the world for an undernourished child.

Tonsils and teeth! Here one seems to come up against an insurmountable obstacle. So many children have diseased tonsils which are affecting their ears, and in some cases that alone is responsible for the malnutrition, while some tonsils are so enlarged that it does not seem as though the children could swallow. Teeth are even worse. Because they lack the proper foods for building strong teeth, decay sets in early, and with lack of care, they go quickly.

The majority of the people are not entitled to clinic care, as they are not residents of the county. County hospitals already have over-crowded dental and throat clinics, and they cannot care for non-residents.

Each county is carrying on its own public health program and has all it can do to reach its own residents. During the harvesting season a large number of migratory families move into the community almost over night. It is impossible for the local health authorities to extend their program to them. The county hospitals are over-crowded. The reason for a special camp nursing service is thus evident. If contagion once gets started it may go like wild fire through the camps and community as well. One must be ever on the lookout for any signs of communicable disease.

ATTEMPTING HEALTH EDUCATION

In some camps story hours are held for the children, and health stories and songs as well as character building stories are told. Talks are given to mothers on home nursing and hygiene. The interest is good and they are willing to leave the never ending washing to learn how to care for their little ones when they are ill. Mothers are learning that the awful impetigo sores will yield to treatment; that the hospital is not a place to fear but a place where expert care and treatment will bring back health.

Through the health education of the older girls, it is hoped that when they establish homes of their own it will be of a different type, that their children will have better care and more of a chance than they did. It takes time, patience, and much repetition to change the customs, and abolish the superstitions of generations.

This work is carried on under the auspices of the Council of Women for Home Missions, an Interdenominational Home Mission Board, an organization that is seeking to make life just a little easier and a little more joyous for the boys and girls who are continually "on the go." In almost all sections after the work has been demonstrated one season, the local community is glad to aid in carrying it on the following year. The second year that nursing service was offered in the cotton camps, the growers were so pleased with the results that they supported the work in full, while one county health department carried the work for the last three weeks of the season so it would not have to be dropped. There has always been splendid coöperation on the part of State health and social agencies, as well as local organizations.

Do we not owe something to this army of wanderers? It is they who pick and can our fruits and vegetables, who make our "balanced diet" possible. It is these children who will be the citizens of tomorrow. Do we want them to grow up in ignorance and with a feeling of bitterness toward our social institutions, or shall we, through education and friendship, seek to interpret to them the physical, mental and spiritual ideals for which America stands?

The Industrial Nurse's Responsibility to the Community*

By GUSTAVE WINDESHEIM, M.D.

A SHORT time ago I received a pamphlet in which the statement was made that the industrial nurse has three obligations: first, to her employer; second, to the employee; third, to her profession. To these I think we should add a fourth, namely, to the community. If the industrial nurse wants to assume this fourth obligation, and I think she should, she must make herself acquainted with the aims and functions of the various health agencies outside of the establishment in which she is engaged, and coöperate with them.

In a noteworthy address presented at a meeting of the industrial nursing section at the National Safety Congress in Chicago in October, 1931, Miss Katherine Faville made this statement: "The industrial nurse is no longer recognized as a separate entity but rather as one of the great group of public health nurses working for the larger purposes of community health." Granted that this is so, who in the group of 20,000 public health nurses in the United States has greater opportunities to serve the community than the industrial nurse?

She it is who has first-hand information about the sanitary conditions of the shops in which the wage earner passes his days, especially in those smaller establishments where no doctor is permanently engaged, and she must assume responsibility for recommending to the management methods by which insanitary conditions can be remedied, and possible sickness prevented—much to the advantage of both the employer and the employee as well as to the benefit of the community.

Furthermore, coming in direct and frequent contact with the wage earner, she has an opportunity, second to none, to observe changes in the conditions of his health, and may often, through him, learn much about the health and needs of other members of his family; and, if she does not confine her interest to those within the four walls of her factory, but extends it to the family and the community, she can, by coöperating with existing health agencies, contribute, as no one else can, toward the general welfare and safety of the community. To illustrate, let me give you a few examples which have come to my notice.

LOOKING BEYOND THE FACTORY WALLS

At the beginning of a serious epidemic of influenza, the industrial nurse in one of the factories employing many hundreds of people of both sexes, asked the advice of the Health Department as to how to prevent the spread of the disease among workers. She was given the advice and communicated it to the manager. He ordered all the employees to follow the preventive measures, with the alternative of immediate discharge for non-compliance. The result was that less than one per cent of his force was laid off on account of illness, while in other similar institutions from fifteen to twenty per cent had to quit for a time. This nurse lived up to her obligations to her employer, to the employee, to her profession and to the community as well.

Another nurse noticed that one of the men in the factory was losing his "pep"; one day she noticed that he coughed. He was a young man with a family of small children. She reported the case to the tuberculosis nurse of the Health Department; the man was examined at the tuberculosis clinic and placed in a

*Presented before the Industrial Health and Nursing Section of the Rock River Valley Safety Conference, Madison, Wisconsin, May, 1932.

sanatorium. The children were kept under observation by the Tuberculosis Society and provided with the necessary help to build up their resistance. The man was finally discharged from the sanatorium as an arrested case and for the past two years has been in good health, making a living for his family—an asset to the community instead of a liability, not to say danger, which both he and his family would have become for an indefinite, probably an extended time, had it not been for the watchfulness of that nurse and her coöperation with a community health agency. Thanks to her the children still have their father with them.

Furthermore, on the strength of that one case, the management of the plant arranged for chest examinations of a number of other employees, with the result that three more were placed in sanatoria—more safety for the community, thanks to that nurse.

Another nurse learned of the absence from work of one of the women employees on account of illness. She made it her business to visit her at home. She found her in bed coughing up blood and her little three-year-old boy close by, crying. This was a young widow, trying to make a living for herself and child, she had always been steady at work, did not show any signs of illness, had no cough that was ever noticed. The nurse made arrangements for a physical examination which disclosed an incipient, active tuberculosis, with positive sputum. After a sufficient time at a sanatorium the woman was discharged with disease arrested. She is again able to make a living for herself and her little boy, and best of all, the little boy has his mother with him again and neither he nor his mother have become a permanent charge and a danger to the community.

LOOKING BEYOND THE PATIENT

"How is your family, Mr. Smith?" asked another nurse in a friendly way, while tying up an injured finger.

"Oh, they are pretty well, thank you, only little Billy, you know, he seems to have caught a cold or something. He was out playing the other day and got kinder wet, I guess; anyhow when he came in he was sick at his stomach and kinder pale around the gills. Next day he had something the matter with his throat and was quite feverish, and this morning his skin was rather red, from the cold and fever, I guess. Otherwise he seems to be all right, he eats good. Most of our trouble is with our girl, Caroline, she cries so much of the time. You see, she is nearly nine years old and it worries her so much because she cannot go to school like other children. I guess you don't know, but she had infantile paralysis and is all crippled up. The doctors say there ain't much to do for it, I guess we have to make the best of it.—Thank you, nurse, the finger feels better now. Good-bye."

But it was not good-bye for that nurse. She got busy and as a result of that one friendly question, "How is your family?", a case of scarlet fever was taken to the Isolation Hospital that day, and a discouraged, crippled child was sent to the orthopedic school where she was fitted with suitable braces, is receiving treatment, is able to walk with a little assistance, improving in health, getting a common school education, and above all, is happy—thanks to that industrial nurse.

Many similar instances could be cited from all over the country. They show what can be done by taking an interest in the people we come in contact with and by coöperation with other agencies, and, may I say, health agencies as a whole value that coöperation very highly for they are handicapped without it.

Generalizing a City Service

By PHYLLIS M. DACEY, R.N.

OUR set-up in Kansas City, Missouri, is very different from that of most cities in that there are seven clinics and thirteen well baby stations, fostered by seventeen different organizations, most of them receiving contributions from the Community Chest Fund and to which, until the generalized plan or service was adopted, we assigned full-time nurses.

The only saving factor was that all the nurses were members of the Visiting Nurse staff and supervised by this organization. For some years the salaries of several nurses were paid by the groups to which they were assigned, but gradually this financial responsibility was assumed by the Visiting Nurse Association.

Because of this set-up, the nurses doing specialized work were unevenly distributed, there being entirely too many in some sections of the city, too few in others. For some of the special assignments, the nurses were greatly overworked, and in others there was hardly enough work to keep them busy, but because a nurse was assigned for full time to one organization it was not possible for us to equalize the service properly. Also, it was quite possible for six different nurses to go into any one home, although it seldom happened. It was not at all unusual for one family to be visited by two or three nurses!

After struggling for many years with this arrangement, we finally became convinced that the only cure for such a complicated state of affairs was to change to a generalized nursing program. As such a contemplated change would affect the boards of directors of seventeen other agencies, we had to proceed very slowly.

STUDYING THE SITUATION

In the summer of 1930, at the request of the Chamber of Commerce, the American Public Health Association made a public health survey in Kansas City and we were fortunate in having Miss Sophie Nelson as "Nurse Consultant." Miss Nelson's first recommendation was that as soon as possible we inaugurate a generalized nursing program. Our Board of Directors was delighted with the suggestion and promptly took steps to put the change into effect. The survey report was completed in September, 1930, and within a month, at our request, the Health Committee of the Council of Social Agencies called a meeting to which were invited representatives of all the agencies with which we affiliate. Dr. Schauffler, Chairman of the Health Committee, explained the reason for the meeting and the recommendations of the survey, and I was given the opportunity of explaining in detail. I endeavored to point out the advantages of the generalized as compared with the specialized program, and emphasized the fact that we felt certain that we would be giving each family a far better public health nursing service than under the specialized program.

A few questions were asked and a vote taken—the group going on record as unanimously endorsing the plan and approving its adoption as soon as the Visiting Nurse Association could bring it about. If any organization felt fearful that its own piece of work would suffer, it was not made known, and a few expressed very enthusiastic approval.

TRYING IT OUT IN ONE DISTRICT

Thus in January, 1931, we established a new sub-station and started our first generalized district. In this territory there were three well-baby stations, one small general clinic, and two day nurseries, to say nothing of the bedside, tuberculosis, and prenatal services. The territory included both colored and white patients.

Then our troubles began, and there

was no complication which could have arisen which passed us by. When I look back I wonder that the supervisor and I did not lose our minds! However, we finally decided that if we were able to "put it over" in this district, and live through it, we would be ready for anything else.

GENERALIZING SERVICE BY SERVICE, DISTRICT BY DISTRICT

It did not take us long to see that we had made a mistake in trying to convert all the work at once. Therefore, four months later when we converted the south district we combined the bedside, prenatal, and child welfare work, and when that was well under way, took over the tuberculosis work. This worked much better and we pursued this same method with the remaining territory.

Our third sub-station was established in October, 1931, and before the end of the year the north and central districts were included in the generalized program. These last districts were converted sooner than we had anticipated because of the fact that it was so confusing to have half the city specialized and half generalized. For instance, one family moved from the generalized territory where it had been carried by one nurse to a specialized district, and in the new district the family had to be divided up again as there were three carried cases in the family! (Prenatal, child welfare, and tuberculosis.)

STAFF ATTITUDE TOWARD THE CHANGE

We have not had an entire year of the generalized service but we are all completely "sold" on the program as compared to the specialized service.

The supervisors were all eager to try the generalized plan long before we were ready for it, but some of the staff nurses were not quite so enthusiastic. Those doing bedside and prenatal work accepted the new plan without a question as did those doing tuberculosis work, but the nurses who had been specializing in child welfare for a long time were decidedly skeptical for fear "their babies" would not be properly cared for. Having been a child welfare nurse myself for more than five years, I could appreciate their point of view. However, without a single exception, the entire staff was very philosophical about it, and if some of them were not quite happy, they concealed the fact beautifully. Now I think that I can safely say that they are all convinced that the generalized plan is far superior to the old way and that caring for the family as a whole is decidedly more satisfactory than having the family divided up as to services.

The few doctors who have commented upon the plan have been enthusiastic in their approval.

ECONOMY OF SERVICE

It was not our intention to cut the nursing staff through generalization, but we hoped to effect a more even distribution of nurses. However, for economic reasons, three of the staff who resigned have not been replaced and in spite of this, each month shows an increase in patients and visits over the corresponding month last year, and the staff is more satisfactorily distributed. Under the old plan rather frequent changes were necessary, but at present there is much less need of changing the nurses from one district to another. This is much more satisfactory to the patients and it is a real comfort to the mother to have one nurse advising on all health problems.

We do not deny that, in making the change, the tuberculosis work has been the most difficult to absorb, chiefly because the average nurse is less prepared for it than for other types of work and takes to it less readily. With experience her interest increases rapidly. The nurses rotate in the tuberculosis clinic (one month each) so that they may become familiar with that phase of the work as well as with the city and state sanatoria. One nurse is permanently assigned to the tuberculosis clinic.

We are continuing our special supervisors (child welfare and tuberculosis) as consultants, although each will be in charge of a sub-station and super-

vising the generalized work. That was Miss Nelson's suggestion to us and it seems to be working very satisfactorily.

As time goes on, and we continue to iron out more of the unavoidable wrinkles, we are more and more enthusiastic about the generalized plan—and wonder how on earth we ever handled the specialized program. Of course there are still plenty of tribulations and no doubt there always will be, but they are so few as compared to those encountered in the specialized program, that they hardly disturb us at all. The work in the generalized service can be handled so much more easily that it is almost unbelievable. There is no doubt about the saving in time. We have not carried the new method long enough to be able to make any definite statement as to the saving in cost, although we know that there has been a considerable saving.

We had expected to make the change in converting from a highly specialized to a generalized service in a period of from a year to a year and a half, but the change was actually effected in a little less than a year—eleven months to be exact. We still have the numerous small clinics, well-baby stations and day nurseries to which to supply nursing service, but with the rotation of nurses this is not very difficult now.

Our orthopedic service (after-care of infantile paralysis) still remains as a specialized service with a staff of four nurses—one of whom is a supervisor.

We also have four full-time clinic nurses—these nurses being assigned to two of the larger general clinics (two in each clinic)—for clinic work only.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR NOVEMBER

Experiment in Hospital Social Service Work by Public Health Nurses

By GRACE M. D. MacLAREN, R.N.

THE Public Health Nursing Service of Neighborhood House, Tarrytown, New York, is a part of a three-fold community program of public health nursing, family case work, and recreation. At the present time, the public health nursing staff consists of a director, five staff nurses, and a clerical assistant. There is an affiliation with Grasslands Hospital for student education, one student being assigned at a time for a period of three months' experience. There is also a field supervisor assigned by the County Department of Health on a part-time basis; about three-fourths of her time being spent in staff and student education, field supervision and supervision, or actual field work, in County Health Department activities in the district. The territory covered is divided into five districts and includes a generalized program for public health and bedside nursing in the villages of Tarrytown, North Tarrytown, and Elmsford with a total approximate population of 18,500, and bedside nursing for contracting insurance companies in parts of rural Greenburgh, Irvington, Ardsley, and Dobbs Ferry.

The clinic and health supervisory services available at nursing headquarters are: infant and preschool health conferences, chest clinics and a dental clinic for preschool and school children. The first two activities are part of the County Health Department program, the clinicians being members of the Health Department staff. Funds for the service are secured from pay and part pay patients, contracting insurance companies, the Boards of Trustees of three villages, private contributions and the Community Chest.

DEVELOPING A MEDICAL SOCIAL WORK PROGRAM

A medical social work program was developed in coöperation with Tarrytown Hospital in 1931. It seemed desirable to try this experiment in order to demonstrate to the hospital the need for social work in connection with the clinics. The tie-up with the hospital was completed by assigning the public health staff nurses to act as medical social workers since they knew the doctors and the coöperating agencies, as well as having the confidence of the patients because of home contacts.

Tarrytown Hospital serves the villages of Tarrytown, North Tarrytown, and Irvington, with numerous patients from Elmsford and the country east of the Hudson River. There is a fairly large group of the population who "just get along" in ordinary times. These are the unskilled laborers in the factories; the colored people who are employed as gardeners' assistants, maids, etc.; the perennially unemployed and the drifters. Previously, the nearest clinic service was at Grasslands Hospital, the County hospital four miles away. The Public Health Nursing Service found two problems always present: securing clinic care for patients—getting appointments readily at Grasslands Hospital, which serves the whole county; and transporting patients, either by volunteer service or by paying bus fares for indigent patients.

SHOWING THE NEED OF CLINIC SERVICE

Three years ago an arrangement was made whereby patients could be referred to Tarrytown Hospital on one afternoon a week, to what was called a diagnostic clinic, for want of a better name. Examinations were made in the emergency room by the Resident Physician or one of the attending staff. At the end of the year 173 patients had been cared for in addition to those sent to regular clinics elsewhere. With these figures and some specific cases to illus-

trate the need, the Public Health Nursing Committee approached the Tarrytown Hospital Board with the suggestion that a regular clinic service be established. This was finally acted upon; rooms were remodeled, and on March 1st, 1931, the clinic opened its doors.

JOINT RESPONSIBILITY ASSUMED BY HOSPITAL AND NURSING SERVICE

It was agreed by the Hospital Board of Managers and the Nursing Committee that the success of the clinic was a joint responsibility. Therefore, a joint committee was appointed consisting of two members of the Women's Board of the Hospital, two members of the Public Health Nursing Committee, the Director of Public Health Nursing and the Superintendent of the Hospital. The President of the Hospital Board and the Chairman of the Medical Staff of the Hospital are ex-officio members.

The following rules were agreed upon:

1. There should be no fee for clinic service. (This in spite of the wishes of the Women's Board of the Hospital, and the Public Health Nursing Committee.)
2. The Hospital would be responsible for the conduct of the clinic, and would furnish a nurse for this purpose.
3. The Public Health Nursing Service would furnish a nurse to act as medical social worker for each clinic.
4. A social summary would be prepared for each patient admitted, to show that he was clinic-worthy, and to assist in planning for his care.

HOW THE PLAN WORKS

The routine established was as follows: As much information as possible is obtained when the patient is admitted to the clinic. The nurse-social worker collects all the social histories of new patients before leaving the clinic and clears them through the public health nursing office. If they are already known there, she give the face sheet to the public health nurse carrying the case, to be completed on her home visit. All other face sheets of patients not known to the public health nursing staff are then cleared with the social worker attached to Neighborhood House. She selects the cases known to her and clears the remainder through the Central Index (Social Service Exchange), sending the face sheets to such other agencies as have contacted the patients. All unknown cases are investigated, and the report submitted by the Neighborhood House social service worker.

The follow-up care of the patient is arranged in much the same way. The nurse in charge of the clinic keeps a diary with the doctor's orders and suggestions for the patient. Upon her return from the clinic, she notifies the nurse in the district in which the patient lives, the social worker or the coöperating agency, of the doctor's wishes for the patient, whether a report is expected and the date of the patient's return visit. If the patient is to receive nursing care, the call is given to the nurse in the district, as is any other call.

The clinic services are as follows: orthopedic, medical and diagnostic, surgical, gynecological, skin and salvarsan treatments, obstetric, pediatric, ear, nose and throat. It was estimated that about one-half of one nurse's time would be occupied by this program; and as the Public Health Nursing Service needed additional nurses to cover its own services, funds were secured from private sources and the Community Chest to provide the additional staff nurse. The six clinic services were divided among four of the staff nurses, those having light clinics carry two each; the public health nurse has entire charge of her own particular clinic. The working day is planned as far as possible with reference to the time estimated for hospital social service. The nurse notes the time of entry into the clinic and the name of the service at the top of the page, records all orders or changes in patients' status, the time of leaving the clinic, and signs her name. This diary is kept in a convenient place in the Public Health Nursing Office.

PROGRESS OF THE PLAN

The annual report of the Public Health Nursing Service gives figures for the clinic social service work for nine months, from March 1, 1931, to January 1, 1932, as follows:

Number of clinics served	221
Number of patients interviewed	920
Number of clinic hours	246

The number of patients referred to the clinics by the Public Health Nursing Staff was 116. Many very constructive things were accomplished: patients hospitalized and subsequently given convalescent care, their families being cared for during the interim; various appliances secured; patients in the Salvarsan Clinic followed up for treatment (there has been a minimum of lost cases here), and their contacts examined; special diets and special treatments followed up.

The staff nurses have been greatly interested and have done a considerable amount of outside reading on medical social work. The director of the nursing service arranged for each to visit social service departments in New York City hospitals, where they were greatly stimulated.

The Joint Committee as well as the Hospital Board and the Public Health Nursing Service are satisfied that the trial of this plan has worked to the advantage of all three agents—the patient, the hospital, and the nursing service. They are especially aware of the fact that the clinic came at the exact moment when the community stood most in need of it. The social summaries, like those elsewhere, are one long record of unemployment.

This year, after a careful survey of the results, there seems to be one definite need: a greater feeling of responsibility on the part of the nurse-social worker for the record system at the hospital. Therefore, in September, the clinic social work in all clinics was transferred to one staff nurse. It is estimated that not less than one-third, nor more than one-half of her time will be spent in clinics, and she carries a small district for field work. She will devote the time usually given to education in public health nursing, to social service class work and outside reading.

PARROT FEVER WARNING

The United States Public Health Service advises all persons to avoid contact with recently shipped or acquired birds of the parrot family. Several cases of psittacosis are being reported in various parts of the United States. Reports of five cases and one fatality have recently been received from Minneapolis, Minn. Another case has been reported from Boise, Idaho.

Upon the recommendation of the Public Health Service, the Secretary of the Treasury has recently issued an order amending the interstate quarantine regulations so as to limit the interstate transportation of birds of the parrot family by common carriers to those certified by the proper health authority of the state as coming from aviaries free from infection.

An outbreak of psittacosis or parrot fever occurred in the United States during the winter of 1929-30. One hundred and sixty-three cases were reported at that time, with 33 deaths. Practically all of these cases were traced to association with recently acquired parrots and parrakeets.

Syphilis

Some Facts Regarding Diagnosis and Treatment

By GLADYS CRAIN, R.N.
Assistant Director, National Organization for Public Health Nursing

Editorial Note: This article continues Miss Crain's series on social hygiene begun in our July number. Reprints of this study program are available.

SOME one has said that a cultured man or woman is one who knows "something about everything and everything about something." This definition might well be applied to the public health nurse, who needs an impressive background of knowledge to cope with the varied situations which come to her attention.

Although the diagnosis and treatment of syphilis are prerogatives of the physician, the public health nurse should be familiar with the common methods in use.

METHODS OF DIAGNOSIS

It is interesting to remember that up to 1906 there was no serum test for the diagnosis of syphilis. During that year, however, Bordet and Genjou finished their studies on complement fixation and immunity. Later Wassermann, Neisser, and Bruch applied these findings to syphilis and developed the Wassermann test which with the later precipitation tests has been such a valuable aid in the diagnosis of the secondary and late stages of the disease.

The accurate diagnosis of the early seronegative stage of syphilis has been made possible through the perfection of the dark field microscope. By a special method of concentrating light upon the field to be observed and by use of the highest power oil immersion lens, one may see a host of spirochætes in the clear serum obtained from a primary syphilitic lesion. Since the success of the treatment of syphilis is invariably and directly in proportion to the promptness with which it is begun, the dark field examination for accuracy and speed of diagnosis is extremely important. While the dark field is possibly the most accurate method for recognizing the *treponema pallidum*, it is not always practicable. In such cases stained smears have had considerable success and are being adopted in a number of centers.

The Wassermann and other blood tests which rely upon the phenomenon of complete fixation or precipitation, are, of course, indirect methods of diagnosis in contradistinction to the dark field which is a direct and certain method. Blood tests are an effective but not an infallible means of determining the presence of syphilis, and positive reactions must be interpreted in the light of the patient's history, together with painstaking clinical observations.

THE WASSERMANN TEST

The test most frequently employed is the Wassermann, which has in recent years been modified and improved by Kolmer and others. It is a very complicated laboratory procedure and requires six different reagents to perform it. These are guinea pig serum, rabbit serum, an extract of beef heart or other muscle tissue, sheep's blood corpuscles, human serum, and physiological saline. So many animal reagents add to the cost of the test, making it prohibitive in some communities, and also rendering standardization difficult.

Another disadvantage of the Wassermann test is that it must be performed in two separate steps which take many hours to complete. In spite of these facts it has great value and when used routinely in medical and other diagnostic clinics brings to light many unsuspected cases of syphilis and clears up numerous mysteries where treatment for some ailment which syphilis has sim-

ulated, proves unavailing or baffling.

The complexity of the Wassermann test has served as an incentive to scientists to develop a more simple and if possible more dependable test for syphilis. Most of the attempts have been directed toward precipitation reactions. Those most frequently employed in this country are the Kahn, the Hinton, and the Kline. The Hinton test is highly sensitive in its reactions, and it has considerable prestige in the East—especially in New England.

The Kahn is much more widely employed and in some laboratories is the only test in use. It has certain advantages over the Wassermann, which have contributed to its ready adoption. It takes less than one hour to complete; there is but one step required in its performance; and only three reagents are used. These are extract from normal muscle tissue, which is standardized, human serum, and physiological saline.

The Kline test is much like the Kahn but is performed in half the time, and the reaction is observed under the microscope. An important advantage of the Kline is that a very small amount of blood is necessary for the test. Experiments with finger blood are being perfected, and hold interesting possibilities for the future. Several test tubes with controls are used to demonstrate the reaction of the Wassermann, Kahn, and Hinton.

Nurses frequently ask what a four-plus Wassermann and Kahn look like in the test tube. It would be interesting to go into the fascinating details of these tests, but space will not allow this. Suffice it to say that in a positive Wassermann the fluid in the tube is clear and colorless, with sheep's corpuscles settled in the bottom. In a negative Wassermann there is a laking of the blood corpuscles and the fluid is red in color. A four-plus Kahn shows a heavy precipitate in the mixture, while a negative Kahn is without precipitate.

The best practice according to outstanding syphilologists is to employ more than one type of test for each specimen of blood examined.

INTERPRETATION OF TESTS

Some points for the public health nurse to remember in interpreting blood tests are that they are no guide to the infectiousness or non-infectiousness of a patient; that a single positive test should not be taken as diagnostic; that several positives mean syphilis, and call for treatment; that a negative test in a patient under treatment is not a proof of cure, nor is it an index of any patient's real condition or final diagnosis.

It was at one time thought that patients with such diseases as scarlet fever, tuberculosis, malaria, jaundice, and also women in the last months of pregnancy might show a positive Wassermann test, even though free from syphilis. This viewpoint is today discredited. It is highly probable that these patients also have a syphilitic infection.

It is the usual practice to test the spinal fluid of each syphilitic patient within the first year of his infection—to discover whether the disease has spread to the nervous system. Some clinics perform this test as frequently as every six months. Specimens of fluid are obtained by lumbar or cistern punctures.

Another interesting test tube procedure which has developed in connection with the spinal fluid is the colloidal gold reaction. This test by a curve of changing color indicates whether paresis or tabes is developing.

It is encouraging to realize that in these ways the physician may early become aware of the beginnings of spirochætal activity in the brain or cord, and start special treatment at once to prevent further damage.

TREATMENT

In dealing with the treatment of syphilis two points of view must be considered:

1. The public health and community interest in the control of a communicable disease.
2. The patient's interest in his own cure.

The arsenobenzenes which include Ehrlich's "606" (Salvarsan or arsphenamine), neoarsphenamine ("914"), and sulpharsphenamin are the most effective

drugs in use both from the standpoint of the cure of the patient and the safety of the community. The first two are usually given intravenously, and the last intramuscularly. A few injections of these drugs render dangerous lesions non-infectious by paralyzing and killing spirochætes. These drugs also have a tonic effect on the patient, so that often after a short course of treatment, he feels unusually well and as the lesions quickly disappear he has a tendency to think himself cured. It is very difficult at this point to get him to continue treatment. However, it is said that inadequate treatment is worse than no treatment, since it tends to hasten nerve involvement. Also when treatment is discontinued too soon, relapses may occur with infectious lesions which again make the patient a menace to the community.

In connection with the use of arsphenamine present practice includes bismuth—a heavy metal which is given intramuscularly. This drug not only kills the organisms of syphilis, but also builds up the body's resistance to the disease. As a spirochæticide it is not considered as powerful as arsphenamine, but in certain combinations such as "bismarsen" remarkable results have been demonstrated in those Wassermann-fast cases over which arsphenamine has had little apparent effect.

A third drug is mercury, which has practically no power over the germ itself but is a tonic for stimulating the natural protective forces of the body.

Iodides in various combinations are also useful in syphilis as they dissolve tertiary lesions, relieve pain in periostitis, and are valuable in the treatment of cardiovascular and neurosyphilis.

Neurosyphilis used to be a hopeless and fatal manifestation of the disease. However, since 1921 the use of tryparsamide, malaria therapy and diathermy have produced excellent results. In a study of 542 mental patients treated with tryparsamide 36 per cent were so improved that they were again able to adjust to a normal community life. Research regarding the efficiency of malaria therapy shows about the same percentage of improvement.

REACTIONS TO TREATMENT

There are occasional reactions to treatment with which public health nurses should be familiar. The severe headache following the lumbar puncture can usually be avoided when small gauge needles are used, and the patient rests flat in bed for at least twenty-four hours after the operation.

Some of the reactions following the injection of arsphenamine are due to faulty preparation of equipment, and poor technique; others may result from indiscretions on the patient's part.

Early symptoms of intolerance to the arsenobenzenes are general malaise, headache, nausea, and nitritoid crisis. The latter reaction is recognized by flushing of the face, swelling of the lips, choking, coughing, difficulty in breathing, and cardiac distress. The theory usually put forward is that this is a protein or anaphylactic intolerance. Adrenalin gives almost instant relief. Later reactions may simulate nephritis, jaundice, and various dermatoses.

The commoner forms of reaction to mercury and bismuth are stomatitis, kidney complications and gastro-intestinal disturbances. In bismuth intolerance a blue line showing along the margin of the gums means the beginning of trouble.

A grave reaction in tryparsamide treatment is eye involvement, which may begin with a slight irritation and go on to a gradual narrowing of the field of vision and final blindness.

The important thing for the nurse to remember is that any abnormal symptoms which a patient, who is under treatment, may complain of, are worth noting, and reporting to the physician in charge.

HOME VISITING

There is as a rule very little actual nursing care to be given to syphilitic patients in their homes, as they are, in the majority of cases, ambulatory and quite able to do for themselves. For those occasional patients who need bed-

side care, the skills which are acceptable in medical, surgical, and mental disease nursing apply. For example, the nursing care of a heart case does not change in principle because the patient's lesion is syphilitic in origin.

In 90 per cent of the cases brought to her attention in the field, the public health nurse's rôle will be that of teacher. In such instances the content of her home visits will include the following:

1. An investigation of the home situation to ascertain whether it is favorable from the standpoint of treatment; and whether instructions given by the clinic or private physician can be adapted to the limitations of the environment.
2. Teaching the facts of the disease; what it is; how it is spread; the possibility of cure; the value of adequate treatment and the results of inadequate treatment.
3. Demonstrating precautionary measures if the disease is in a communicable stage; and assisting the patient with plans for carrying them out under the possible difficulties of his home surroundings.
4. Demonstrating special treatments.
5. Teaching personal hygiene and general health measures.
6. Extending preventive teaching to all members of the family since disease is a family matter.

Dr. David Lees reiterates the importance of good hygiene and the maintenance of good health as an aid in the cure of syphilis and a preventive of intolerance to drugs. Congenital syphilitics especially need good food, fresh air, sunshine, cod liver oil, and plenty of rest, if satisfactory results are to be obtained.

Special teaching of mouth hygiene is necessary—and all carious and broken teeth should be attended to. A clean mouth, brushing the teeth three times a day, and using an astringent mouth wash are aids in preventing stomatitis.

The omitting of all food for several hours before treatment and the avoidance of alcohol are also preventives of untoward reactions to the drugs.

Tact and skill in teaching are prerequisites in working with these families. It is a common error to try to force an issue, when one is impatient for results. It is also easy to confuse teaching and telling. A patient is never motivated by a string of facts. New ideas—better modes of living—must be related to his interests, and framed within the restrictions of his environment, his intelligence, and knowledge. Only then will he see their value for himself, and *act*. Only then can the nurse consider that she has taught.

QUESTIONS

1. What is the average length of time that patients with syphilis continue treatment in your own organization?
2. What are the reasons that patients give for lapses? List these in the order of frequency.
3. What can you do in the light of these reasons to improve case holding among this group?
4. Outline what you would tell a patient who thought he was cured after a few injections of arsphenamine; one who had an unfortunate reaction to treatment and refused further injections; one who has had one negative Wassermann after a course of treatment; a pregnant syphilitic mother who feels perfectly well and can see no reason for hospital care or medicine.
5. How would you explain the value of a routine Wassermann to a pregnant woman?

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The National Federation of Belgian Nurses

By J. PARMENTIER

Secretary General, National Federation of Belgian Nurses

Editorial Note: Again, in preparation for the Congress of the International Council of Nurses (Paris-Brussels, July 10-15, 1933), we are publishing a description of one of the nursing organizations with which visitors will want to be familiar.

IN spite of efforts in Belgium, since 1907, to introduce the principles of Florence Nightingale into nursing, we can say that not until 1918 did they really take effect in our country. Nurses working in the hospitals, particularly those who had served at the front during the war, felt the imperative need of forming a professional association which would yield moral support, promote their interests, and raise nursing to a position where it would be understood, recognized, and appreciated.

In 1918 a group of nurses met with the aim of creating interest in the founding of such an association. They wrote to America to get information, and Countess d'Ursel, who was studying at Teachers College, New York, received encouragement and advice from Miss Adelaide Nutting, who has always been interested in the nursing problems of the various countries. In 1919, forty nurses from different public and private hospitals met in Brussels and founded The Nurses' Professional Association. The organization began a study of working conditions for nurses; this included four items, moral conditions, one national official diploma, working hours, and salaries. At the instigation of the Association, the first Refresher Course was given for nurses, and, in coöperation with the Nurses' Club, an employment bureau was established for private duty nurses.

In February, 1922, the delegates from the different provincial organizations met again in Brussels, and voted unanimously for the foundation of a National Federation of Nurses. The organizations from Brussels, Antwerp, Malines, Ghent, and Tournai, as well as the Public Health Nurses' Association of Belgium, were admitted to membership in the Federation.

The new Federation then took steps to affiliate with the International Council of Nurses and was admitted at the meeting of the Council in Copenhagen in May, 1922. One of the first acts of the Federation in relation to a foreign group was to send financial aid to the Japanese nurses after the earthquake of September 1, 1923.

Among the activities of the Federation have been several experiments with insurance schemes. In 1924 the Federation took an active part in organizing an insurance society which was called "Mutual Insurance for Nurses and Social Workers." This society has now 1,750 members; it pays daily indemnity in case of illness, provides medical service and medicines, and supplies pensions in case of disability and old age. Through a measure passed in 1925, nurses are admitted as employees into the pension fund and employment contract.

The same year the Federation obtained from the Minister of the Interior the promise that it would be consulted in the case of proposed amendments to the Royal Decree of September 3, 1921, requiring a three-year course of training. Soon after this a committee was organized to revise the curriculum for the course, and Mlle. Hellemans, President of the Federation of Nurses, was appointed a member. When in 1926 this committee discussed the possibility of training practical nurses, the Headquarters of the International Council of Nurses was so interested in our problem and our efforts, that Miss Reimann came to Brussels to assist in our proceedings with the Minister.

The Federation collaborates closely with organizations employing nurses; this provides a wide field of activity and we cannot do justice to the numerous demands which come to us. Certain organizations, because of their importance and the large number of nurses they employ, have delegates in the Council of the National Federation of Nurses; such is the case with the two great associations—the Belgian Red Cross Society and the National Child Welfare Association.

Since its foundation the Federation has wished to have a uniform which would be worn only by graduate nurses, members of the Federation. In 1924 this desire was realized, and at the International Congress at Helsingfors in 1925, our delegates were dressed in their pretty grey uniforms.

There are at present 22 schools of nursing in Belgium following the curriculum of the Royal Decree of 1921; they train hospital and public health nurses for State diplomas. There are four training institutions for nurses wishing to add to their diplomas the mental nursing certificate. The University Hospital of Louvain has an affiliated school of nursing, and we hope to see a similar affiliation at the Hospital St. Pierre, which is connected with the Medical School of the University of Brussels. The School of Tropical Medicine prepares nurses for colonial nursing work.

The Federation, always anxious to see its members better prepared for their work, arranges each year a series of Refresher Courses under the direction of superintendents and instructors of schools of nursing.

A periodical, *l'Infirmierè*, is published regularly by the Federation in both French and Flemish, and is sent to 1,200 subscribers as well as to twelve foreign countries in exchange.

We shall be glad to show the nurses who attend the 1933 International Congress at Brussels—especially those who advised us about the establishing of the National Federation—what can be accomplished by tenacious work. Certainly we have had difficult times, but what has been accomplished in ten years is a guarantee of the development and the future of the Federation.

TRANSPORTATION RULES

The Committee on Transportation of Allied National Agencies* which concerns itself with rules (their interpretation and application) for transporting indigents from place to place, has issued recent rulings which may be of interest to nurses who are faced with the problem of receiving or sending on indigent patients or their families.

Before any transportation shall be provided, the agency considering it shall be satisfied by adequate and reliable evidence that:

(1) The prospects of the applicant in opportunities for normal living are not decreased by sending him to the proposed destination.

(2) The applicant

(*a*) Will have such resources for maintenance at the point of destination as will save him from becoming dependent on relief from an agency, public or private, *or*

(*b*) Is a proper charge upon the agencies there, *or*

(*c*) Has legal residence there.

(3) Reasonable effort has been made to obtain from an appropriate agency at the proposed destination a report as to the facts included in Rules 1 and 2.

(4) Provision has been made for the applicant through to the ultimate destination which has been determined by the sender.

*Room 504, 25 West 43d Street, New York City.

CONTRIBUTORS PAGE

WALTER E. HAMMOND, Ed.M., was born in Stonington, Conn. He graduated from Plainfield (N. J.) High School, Worcester Polytechnic Institute, Penn State College, Harvard University (A.A.), and Boston University (Ed.M.). He has had twenty years' experience in educational work, as elementary teacher, principal, supervisor, high school teacher, and superintendent of schools in Connecticut, Massachusetts, New Hampshire, and New Jersey. He writes that he is "an old-time 'naturalist,' special hobbies being mineralogy and geology. Especially interested in health and improvement in health of the school children."

MRS. ALICE FITZGERALD, R.N., was born in Quincy, Illinois. She was educated in England and trained at Blessing Hospital, Quincy, Illinois. She worked two years and a half with the Brooklyn (N. Y.) Visiting Nurse Association and took a special course in Orthopedics at Long Island Medical College. She was registrar for the Wavecrest Convalescent Home for Crippled Children for four years, and is at present secretary of the Information Bureau and Clearing House of the Children's Welfare Federation of New York City.

EDNA LOCKE HAMILTON, R.N., holds the degree of A.B. from DePauw University, and is a graduate of the Wesley Memorial Hospital School of Nursing, Chicago. She has had postgraduate work in public health and nursing education at the Chicago School of Civics and Philanthropy, and Columbia University. Public health experience includes: field work, Chicago Tuberculosis Dispensaries, and direction of the Public Health Nursing Association of Indianapolis, Ind. She is at present Director of Nursing Division, Children's Fund of Michigan.

H. EVA BARNES, R.N., is a graduate of the University of California and also a graduate of the University of California Hospital. In 1931, she took the Public Health Nursing course in Summer School at the University of California.

For the past three years and a half she has been doing health and social service work in migratory labor camps in California, under the Council of Women for Home Missions.

GUSTAVE WINDESHEIM, M.D., is a graduate of Northwestern University Medical School. He is director of the Health Department, Kenosha, Wisconsin; president of the Wisconsin State Board of Health, ex-president of the State Medical Society of Wisconsin, and a member of the Executive Committee of the Wisconsin Anti-Tuberculosis Association.

PHYLLIS M. DACEY was born in Boston and is a graduate of the Children's Hospital there. Positions held include: Assistant Superintendent, Children's Hospital, Columbus, Ohio; Staff Nurse, Baby Hygiene Association, Boston, Massachusetts; Army service with Base Hospital No. 5 in France—twenty-three months; Assistant Superintendent, District Nursing Association, Fall River, Massachusetts; Assistant to Director and Acting Director, Public Health Nursing, Northern Division, American Red Cross, Minneapolis, Minnesota.

Present position: Director, Visiting Nurse Association, Kansas City, Missouri.

GRACE M. DUBOIS MACLAREN writes: "I received my early education in Schenectady, N. Y., and graduated from the Ellis Hospital Training School for Nurses in that city. Chronologically arranged, my experience has been as follows: School nurse in Schenectady Public Schools; U. S. Army Nurse Corps in England and France, Base Hospitals No. 33 and No. 69; organized the Red Cross Public Health Nursing Service in Johnstown, N. Y.; staff nurse, Maternity, Infancy, and Child Hygiene Division, New York State Department of Health; staff nurse, Henry Street Visiting Nurse Service; medical social worker, Mt. Sinai Hospital Social Service Department, New York City; Director, Public Health Nursing Service, Tarrytown, N. Y.

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by ALMA C. HAUPT

STATE CHAIRMEN FOR 1933 N.O.P.H.N. MEMBERSHIP CAMPAIGN

(The states not listed had not been heard from at time of going to press. Their names will appear in a later number).

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District of Columbia—Gertrude Bowling
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N.O.P.H.N. STAFF ACTIVITIES IN THE FIELD DURING SEPTEMBER AND OCTOBER

Miss Tucker: A.P.H.A. Meeting, Washington, D.C.
American Association of School Physicians, Washington, D. C.—Paper.
Kentucky State Nurses' Meeting.
Institute on Supervision, Connecticut.
Miss Haupt: A.P.H.A. Meeting, Washington, D. C.
Hampton Institute—Conference on Negro Nursing—Paper.
West Virginia State Nurses' Meeting—Paper.
Mrs. Hodgson: A.P.H.A. Meeting—Paper.
New York State Nurses' Meeting—Paper.
Tuberculosis Institutes at Red Bank, N. J., and Brooklyn, N. Y.

STAFF ACTIVITIES

(Continued)

Connecticut State Nurses' Meeting—Paper.
Survey of Tuberculosis Program, District Nurse Association, Providence, R. I.
Miss Davis: A.P.H.A. Meeting.
Welfare Conference, Junior League, Boston.
Illinois State Nurses' Meeting—Board Members' Program.
Institute for Board Members, East St. Louis, Ill.
Pennsylvania State Nurses' Meeting.
Miss Deming: National Safety Congress—Industrial Nurses' Section, Paper, Washington, D. C.
Miss Tittman: New York State Nurses' Meeting (Chairman of Program Committee).
Miss Royer: Office.
Miss Tattershall: Office.
Miss Carter: Vacation to October 6.
Visit to Simmons College, Boston, Public Health Nursing Course.
School Nurses Section, Massachusetts Organization for Public Health Nursing, Boston—Address.

BOOKKEEPING SYSTEM FOR COST ACCOUNTING

Many of our readers have received a copy of the book called "Principles and Practices in Public Health Nursing Including Cost Analysis," in which there are definite recommendations as to methods of arriving at a cost analysis of nursing service. As several agencies reported to us that it would be a great help if they could have these recommendations translated into a bookkeeping system so that they could be sure that their method of keeping accounts would give the material desired, the Service Evaluation Committee of the N.O.P.H.N. consulted trained accountants and worked out such a system. Mr. Thomas Scott, who has charge of this phase of the nursing service for the Metropolitan Life Insurance Company, has been of the greatest assistance and assures us that the system which has been developed will entirely meet the requirements of the insurance companies for cost figures.

Included in the book are the requisite number of sheets for disbursements, for receipts, ledger sheets, time and visit sheets and instructions as to how to use them. Obviously, the great advantage in using such a book is that one may be sure that it is in accordance with the recommendations of the Committee as to cost analysis, which recommendations have been accepted by the insurance companies as their basis for payment. It would be an exceedingly costly matter for each agency to employ an expert accountant—and it certainly would take an expert to work out such a system—and to have the forms printed just for one agency. Description and prices of this system will be found in the advertising pages of this number of our magazine.

CALENDAR AND CHRISTMAS CARDS

This year the National League of Nursing Education is presenting a calendar of quotations which will make an appropriate gift for everyone. The title is "Quo Vadis?" and within its pages will be found quotations from some of our modern educators and philosophers, such as Whithead, Dimnet, Lippmann, Dewey, and others. Interspersed here and there will be found quotations from some of the old writers, which are just as modern as though they were written today. The cover page is in color from a painting by H. Willard Ortlip, and the beauty of the picture will be a source of pleasure long after the calendar is used up.

The price of the calendar will be, as heretofore, $1 per single copy, and 75 cents per copy on all orders of fifty or more, delivered in one shipment.

In addition to the calendar there is offered a set of six distinctive Christmas cards on nursing subjects. Five of these cards are sketches in black and white and one is in color. They are the work of Miss J. H. Stewart. The subjects represent the nurse in various fields of work. Two cuts of the public health nurse are shown here. The titles of the six are:

"The Nurse Pays Her Christmas Calls in the Far North."
"The Children's Christmas"—scene in children's hospital.
"Christmas Holidays Begin"—the school nurse.
"On Christmas Morning"—the private duty nurse.
"The Carolers"—student nurses.
"The Visiting Nurse Brings Christmas Cheer."

The League depends upon the proceeds of the calendar and card sale for maintaining its activities.

Individual or assorted cards with matching envelopes may be ordered in lots of six or one dozen. The price is 6 cards and envelopes for 50 cents (unboxed), or $1 per dozen (in attractive Christmas box). Order from the National League of Nursing Education, 450 Seventh Avenue, New York, N. Y.

BOARD AND COMMITTEE MEMBERS FORUM

Edited by KATHARINE BIGGS MCKINNEY

TOPIC III

NEWSPAPER PUBLICITY

(This is the third outline in the study program on publicity)

The newspaper is one of our most important avenues of approach to the public. We have in it a medium which is read by all and quoted daily. It is of real value to any welfare group but to use it successfully much depends upon the character and timeliness of the material we submit for publication, the manner in which it is prepared and the contact we have with the newspaper personnel.

Newspaper publicity is going to be difficult to obtain this year. Due to the business situation, the papers have less advertising material so that their space is limited. Also, we are in the midst of a presidential campaign and there are many pressing public questions at issue. We have had so much in the press about the effects of the depression that some newspapers are interested only in upward trends. All these facts will make it harder to get material published. It is a challenge to us to get unusual stories and presentations that will survive the competition for space. We must make friends with the newspapers, recognize their problems, and give them the kind of material that will really interest their readers.

Before analyzing your newspaper articles which have appeared during the last year and the articles which we have collected for discussion, it is well to be familiar with the various types of material published by a newspaper. The following questions should be answered and the reference readings will give you the necessary information.

NEWS COLUMNS

A. *Sources of material:*

1. The most important requirement in submitted material is news value.
   a. Define news.
   b. List the important events in your organization for the last six months which possess news value.
   c. What is the value of uniqueness?
2. Information may be made interesting by relating it to current topics of general interest. Illustrate how you would make this fact acceptable to a newspaper: The nurses are finding that many mothers are giving children coffee and tea instead of milk.
3. What is the value in using the names of people?
   When should names be suppressed?
4. What do we mean by a human interest story?
   Illustrate from current newspapers.

5. How may news items or statements of general nature be made local?
   How would you use this pronouncement for your local paper: Walter Lippmann, speaking at the National Conference of Social Work, said: "Social workers have done a good job."

B. *Preparation of material:*

1. What do we mean by "news shape"?
2. How should the "lead" be written?
3. What is newspaper style?
4. How should manuscript be prepared for the newspaper?
5. Is it better to mail material or deliver it in person?
6. When should material be in the hands of the newspaper?
7. To whom do you address your news items?

EDITORIAL PAGE

1. Does your local paper accept editorial material from outside the newspaper staff? If not, how may you secure notice on this page?
2. What is the difference between editorials and news releases?

LETTERS TO EDITORS

1. What is the value of using this section?
2. What kind of letters are barred?
   Clip examples of good letters.

(It is possible to prepare informative letters or letters of endorsement and ask a prominent citizen to sign and send for publication in this section.)

SPECIAL CAMPAIGNS

Some newspapers feature special campaigns (such as immunization campaigns). Has this been done in your locality? Was the material supplied by you or was a special writer assigned by the paper? Do you check special writer's material before publication?

NEWS STORIES

The writing of a successful news story (not an editorial, not a feature story) calls for definite, but very easy, technique. The best way to acquire this is to practice, but much can be gained by studying examples of successful news releases. We suggest you select for discussion the examples printed here and four or five of your own past releases. Be sure to use *news* stories only.

1. Is the story written in acceptable news form?
   a. Is the fact most likely to interest readers given in the "lead" (the opening paragraph) where it belongs, or is it in a later paragraph?
   b. Does the "lead" state concisely the main facts, especially time, place, persons, and occasion? Does the sentence begin with an attention-getting name, phrase, or fact?
   c. Does the story consist of a simple and clear statement of fact? Note any obscure words or involved sentences which should be omitted or re-written.
   d. Is a speaker or other definite source cited as authority for any statement for which the newspaper should not be asked to assume responsibility?
   e. Is the story free from laudatory comment unless directly quoted, which belongs in the editorial rather than the news columns?
   f. Could the story be cut off at one of several points before the end and still appear complete? (It is well to allow for this, since many newspapers must "cut" and prefer to cut the end.)
   g. Do the capitalization, punctuation, use of titles, etc., conform to local newspaper style?

2. Does the story contain information likely to interest any considerable number of newspaper readers?

3. Has the story publicity value for the organization or the movement sponsoring it?
   a. Mark passages which enlighten or remind readers about aims, spirit, methods, needs, problems, or results of your work.
   b. Mark passages which tend to create or retain good will toward the organization or movement.
   c. Are there any other tangible evidences of publicity value?

(Many of these preceding questions are taken from "A Brief Course in Social Work Publicity" by Mary Swain Routzahn and used with the kind permission of the author.)

SAMPLE NEWS STORIES

M'SS EMILY GOETZE HOSTESS AT CAMPAIGN TEA

Miss Emily Goetze, chairman of teams in the campaign which will be held by the Visiting Nurse Association of Brooklyn, January 16 to 30, was hostess at a tea yesterday afternoon at her home, No. 60 Remsen Street. Miss Goetze and Mrs. William Denny Sargent, general chairman of the women's organization in the campaign, told of plans for the campaign. Mrs. J. Morton Halstead, president of the Visiting Nurse Association, in a short talk told of the emergency facing the association during the present period of unemployment. Five nurses have been added to the staff, bringing the number of visiting nurses in the borough up to 125 and more nurses will be added to meet the need, she said.

Short talks on the work of the nurses in giving bedside care in homes throughout the borough were made by Miss Elizabeth Stringer, executive director of the association, and Mrs. Kenneth J. Hollinshead, a lay member of the association who was formerly on the staff of the National Organization for Public Health Nursing. Miss Stringer called the attention to the fact that the nurses take care of patients over an area of eighty-one square miles.

NURSES HERE WILL ADOPT NEW HOURLY APPOINTMENT PLAN

Marshalltown nurses, acting through the organization represented by the graduate bodies of the Deaconess Hospital and St. Thomas' Hospital, have determined to adopt the hourly appointment nursing service plan, which has proved so efficient throughout the east in recent years, it was announced here today.

The primary purpose of the innovation is to serve the public economically and in terms of needs not now being met adequately. It is not intended that this service will supplant the work that is being done by the Visiting Nurses' Association. Rather it will extend that service, to those families or patients who need more constant care than the visiting nurse is able to give. It is for the patient who does not need continuous service, but whose condition would be benefited by one, two, or three hours of nursing care daily or weekly that the new service is intended.

Hospital authorities having studied the plan, as recommended by the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing, have given their approval to the introduction of the plan in Marshalltown.

(News story reporting a committee meeting)

Extension of much needed social service in addition to food and lodgings is being made to increasing numbers of transient and homeless men through the Central Bureau for Homeless and Transient Men, according to a report of Fred Zappolo, director of the Bureau, to a meeting of the Central Bureau Committee, held Friday noon, at the Wayfarers' Lodge.

"Through sympathetic treatment of the homeless man we are being able in many cases to change the fundamental philosophy of the transient man from one of gloominess and introspection to one of self-respect and improved morale. Particularly do we feel the necessity for doing this kind of case work with the young men who are referred to our Bureau. Last month we cared for 124 boys under twenty—just at the age when many of them may easily be led into a criminal career.

"The case of 'Joe' is an interesting one, presenting many difficult problems to the social worker. He was estranged from his parents, over-emotional, with tendencies to alcoholism and immorality, and at the time he came to us was in poor health and unable to work. Through much work, both with him and his parents, he has been reconciled to them and has returned home, is taking regular hospital treatments, has become interested in preparing himself for a job, has enrolled in night school, and has renewed his interest in his parents' church."

The Central Bureau Committee, of which Woods King is chairman, extended a vote of thanks to city authorities for their very excellent coöperation with the Bureau, and registered their appreciation also of the Wayfarers' Lodge for providing food and shelter to so many of the Bureau's men.

The Committee voted to reaffirm their approval of the policy that no able-bodied man should be given either food or clothing without a work test, such as is available at the Wayfarers' Lodge. They voted also that no help should be given to automobile transients where there are groups of single men touring the country, unless such men are willing to have their records looked up, since records show that many such men have stolen the automobiles.

Comment on the good and bad points in these releases.
Rewrite one more effectively.

REFERENCE READING

"Publicity for Social Work," by E. G. and M. S. Routzahn, published by the Russell Sage Foundation, New York, price $3.00. Chapter V, "The Newspaper," pp. 68-89; On Form of Style, pp. 19-28; The Human Interest News Story, p. 73.

"Newspaper Writing and Editing," by W. G. Bleyer, published by Houghton Mifflin. Human Interest or Feature Stories, Chapter IX, pp. 239-250; and the paragraphs "The Lead" and "Playing Up the Feature," pp. 36-90.

"Control of Tuberculosis in the United States," by P. P. Jacobs, published by the National Tuberculosis Association, 450 Seventh Avenue, New York. Chapter VII, "Newspaper Publicity," p. 36.

"The Newspaper as a Social Agency," by Sevellon Bron, Managing Editor of the Providence Journal, at Philadelphia Conference of Social Work, 1932. Mimeographed copy from the Social Work Publicity Council, New York, 15 cents.

Questions or problems growing out of the study of this outline will be answered by the N.O.P.H.N. Single reprints of this outline free to N.O.P.H.N. members, 10 cents a copy to others; complete Study Program, 75 cents.

MRS. G. BROWN MILLER

In the death of Mrs. G. Brown Miller, which occurred in Washington, D. C., on September 1, 1932, public health nursing has lost a valued friend.

Mrs. Miller became a member of the Board of Managers of the Instructive Visiting Nurse Society of Washington in 1911 and served as Vice-President since 1922. She considered membership on a Board as an opportunity for service. She studied the work of the Society and was quick to grasp the importance of public health nursing to the well-being of the community. She gave generously of herself and her vision and enthusiasm acted as a stimulus to others who served with her. Her loss to the Instructive Visiting Nurse Society's Board is irreparable and is shared by other groups with whom she served in public health.

Her realization of the important part members of boards could play in interpreting the work to the public led her to the realization of the importance of board education. At the meeting of board members of the National Organization for Public Health Nursing in Atlantic City in 1926, when for the first time the lay group became conscious of themselves, Mrs. Miller was one of the first to think of forming a committee and to appreciate the value of a definite organization. Naturally she visioned a place in the magazine where there could be an exchange of ideas and discussions of topics which should knit the group more closely together. This department, the Board Members' Forum, grew out of her suggestion and she acted as editor of it for four years.

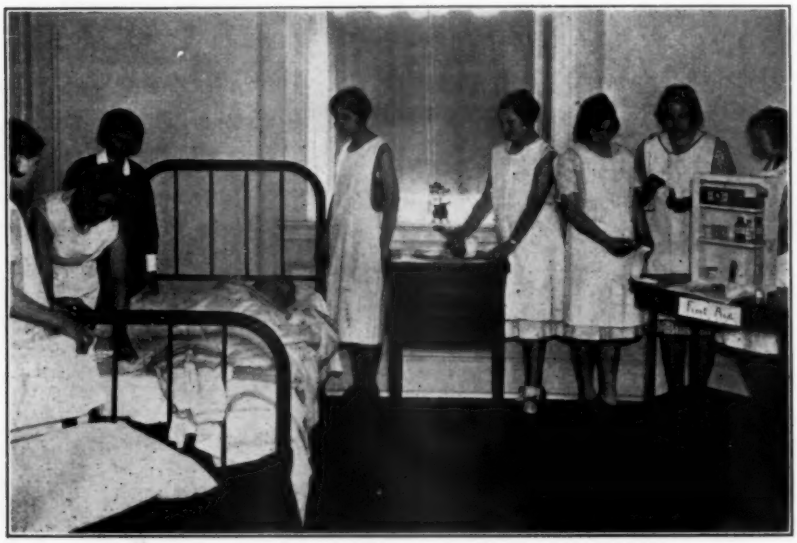
Immediately there came many demands for guidance in board management and again Mrs. Miller was quick to see the need for a board members' manual. Fortunately the National Organization for Public Health Nursing, always welcoming suggestions, met the ambitions of the lay group more than half way. In 1927 a Committee was formed to compile the *Board Members' Manual*. Mrs. Miller was the Chairman of the Committee. For three years the Committee worked and those of us who were privileged to serve on it can pay the deepest tribute to Mrs. Miller's leadership, her sense of fair play and her desire that each feel free to express her opinion. There was no one better fitted for such a task. Her clear understanding of the basic principles of public health nursing, her vision of the part it should play in the life of the people and her faith in its future was an inspiration to us all.

Mrs. Miller was deeply religious. She was endowed with a vivid personality, a generous heart and an understanding mind. To those of us who have worked with her, her memory will serve as an inspiration to continue the work to which she contributed so much.

VIRGINIA CROSS, *President,*
Instructive Visiting Nurse Society, Washington, D. C.

SCHOOL HEALTH

THE SCHOOL NURSE IN THE HOME ECONOMICS PROGRAM



Eighth Grade Girls Demonstrating Bed Making, First Aid, and Breakfast Tray for Bed Patient

In York, Pennsylvania, we have worked out a satisfactory program for the four school nurses correlating with the program of the Home Economics department. In the development of units of work on Child Care and Home Care of the Sick, the demonstration service of the school nurse is closely integrated with the instruction given by the home economics teacher. It is a vitalizing element rather than a supplementing element in the process of pupil learning.

In York each school nurse has a Junior High School under her supervision and several grade schools (2,500 pupils per nurse). The supervisor has the Senior High School and a Junior High. The nurses have received preparation for this work through summer sessions at Columbia University and Penn State College.

At the beginning of each school semester the supervisor of school nursing and the director of the home economics department confer and the home economics director gives the dates when the demonstrations will be needed in the schools. These dates are relayed to the school nurses who plan their work so as to be ready to present the demonstrations related to home care of the sick and care of the baby. These demonstrations fall under the programs in Home Management, Child Care, and Family Relationships. The demonstrations are used to impress the subject matter more thoroughly on the minds of the seventh grade students. Bed-making is a part of the Home Management program for eighth graders.

The Home Economics department has entire charge of the program—the school nurse demonstrates only—the teacher is always present.

The demonstrations cover the following topics:

Child Care, Seventh Grade

1. Handling the baby
2. Clothing for baby, including baby's bed
3. Dressing the baby
4. Bathing baby

Bed Making, Eighth Grade

1. Care of bed in home. Making empty bed
2. Making bed with patient in it.

Probably the most important factor which contributes to the teaching success of the school nurse, as well as the home economics teacher, is the ability to limit the teaching content to the capacities of the pupils and their present needs in a normal home environment.

The program as set up in York, aims definitely to encourage pupils to be more helpful in the care of younger brothers and sisters, and to perform better the ordinary preventive and remedial health practices for themselves and for other members of the family. The demonstrations given by the school nurse—handling the baby, dressing the baby, bathing the baby,

Demonstrations Assembled for the Picture-Child Care by Seventh Grade Girls

first aid procedures, making a bed with the patient in it—followed by pupil participation in the activities observed, have proved to be the most tangible as well as the most effective form of teaching.

Increased pupil interest and improved pupil learning is the inevitable outcome. Results of tests given by home economics teachers are indicative of broad understandings on the part of pupils, as well as a knowledge of fact. Comments from parents testify to the functioning of this instruction in the home. It is evident that there is much value in, as well as much need for this type of service from the school nurse. To this end the professional service of the nurse should be consciously extended.

Louise W. Johnson, R.N., Supervisor of School Nursing,
York Public Schools and York Visiting Nurse Association
Florence M. Gleitz, M.A., Director of Home Economics,
City Public Schools, York, Pa.

REVIEWS AND BOOK NOTES

Edited by DOROTHY J. CARTER

COMMUNITY HEALTH ORGANIZATION

Edited by Ira V. Hiscock. The Commonwealth Fund, New York. $2.50.

Public health workers have waited patiently for the Committee on Administrative Practice of the American Public Health Association to publish the revised edition of "Community Health Organization." At this period of economic distress when all administrators are being challenged to prove the merits of their work, this volume will be welcomed as a manual to study the adequacy of programs, and as a much needed textbook to provide information for lay people whose intelligent coöperation must be secured.

Obviously this book must be given respectful consideration because it is the result of a painstaking collection of information concerning the health administrative practices in more than two hundred communities of varying sizes and conditions. A careful analysis of the data has been made by a group of representative health workers headed by Professor Ira Hiscock, who prepared the manuscript.

The volume is a manual—an everyday reference book—containing information regarding the factors which must be given consideration in the inauguration and maintenance of an adequate health program. Governmental responsibility, organization, administration, program and methods are discussed with due consideration to the allied community activities of hospital and outpatient facilities and to non-official health services. The plan outlined including the budget and personnel suggestions is based on the needs of an average community of 100,000 people but may be easily applied to communities of any size. Reference is made to valuable source material which places at the disposal of the reader a reliable bibliography for research in public health and allied subjects.

Each chapter is a text in itself dealing completely with one phase of a public health program but clearly related to the next chapter because of its relationship to the whole plan. Objectives are clearly stated with discussion of the elements involved in the initiation and carrying out of each phase of the program under consideration. The procedure is logical and "builds up step by step a health organization competent to deal adequately but in no extreme or fanciful fashion with the fundamental problems of municipal administration."

This book should be in the hands of every person responsible for the organization, administration, or application of a health program. It should be equally valuable to health officers, public health nurses, to other professional and non-professional workers and to interested lay people.

MARION W. SHEAHAN

AMERICAN STANDARDS AND PLANES OF LIVING

Edited by Thomas D. Eliot. Ginn and Company, Boston. $5.00.

It would have been difficult for Dr. Eliot to have chosen a more opportune time than the present for the publication of his work on American Standards of Living. Standards have been going through a crucial test of reëvaluation and need to be defended now more than ever before. Consequently, this comprehensive volume, which contains selections from pertinent contributions to the subject will be of distinct value. Prepared especially as a text for the use of students of social economy, it seems to this reviewer that the volume should be of value also to those workers in community health and welfare who are already in the field.

The editor has gathered his selections from a variety of sources. Economists, sociologists, educators, writers, ministers, labor leaders, social and health

workers all speak. They express themselves differently, but their message is essentially the same throughout. It is in part at least the completeness with which the sources for evidence have been tapped that makes the book so valuable and stimulating. Defining a standard of living as a "set of attitudes toward certain values—goods and services, economic or non-economic," Dr. Eliot points out that it is made up of those values which are insisted upon "and for the securing, maintenance, or restoration of which active efforts and sacrifices will be undertaken." The contributions of the various groups mentioned are then brought together on individual and group standards, the struggle for standards and their maintenance, changing standards, luxuries, the place of natural resources in community standards, budgets and thrift, standards and the birth-rate, threatened standards, and finally, standards as tests of progress together with those for the future community.

Reading the selections chosen, one realizes that the struggles of today are by no means new—that generations have striven for a living wage as we do now and with no less determination, though with smaller opportunity for achievement. The twentieth century has made the standard of one community more readily observed by another and what we see and admire, we endeavor to attain either as individuals or communities.

Since the book has been especially prepared as a text, it is admirably compiled with general and specific reference suggestions and with thought provoking questions at the beginning of the sections. In this position, the author believes they are of more productive value than at the close of a discussion. The courage of the workers who have clung to standards during these difficult years will be greatly strengthened by the contributors to this volume who hold these objectives to be of profound importance in the endeavor for individual and community progress.

RUTH W. HUBBARD

THE HISTORY OF MEDICINE: A SHORT SYNOPSIS

By Bernard Dawson, M.D. The Macmillan Company, New York. $2.50.

While a history of medicine in 156 pages sounds somewhat incredible, one has only to read the foreword and preface to this series of lectures to feel that there may be something here of interest and value to nurses, as there apparently was to the group of medical students of the University of Adelaide to whom the lectures were originally addressed. To call the book "a short synopsis" does not altogether do it justice, for one hardly expects a synopsis to provide either background or vitality for the persons or events which it portrays. Here, because of a wise selection of material and skillful characterization, we find both to a rather remarkable degree. As he says, "many episodes of importance and personalities of merit have perforce been omitted," yet those individuals who do emerge appear as surprisingly live human beings who will not be forgotten easily. In spite of limited space, we are not left with an impression of disconnected, sporadic events, but rather of essential continuity. The author does not permit us to forget that the achievements of any given period, including the present, have often had their foundation in, or have actually been, the near-achievements of an earlier time, failing only because of the lack of one essential link.

Obviously for the instructor or for the student of medical history who has time to search out source material, this book will have limited value, although even for these individuals it may serve either to whet the appetite for more or to give the necessary perspective, which can be lost so easily in the midst of many details. To the busy nurse who is engrossed in the problems of the present yet finds in a review of the struggles and achievements of the past encouragement and incentive to further effort, its very brevity, as well as its interesting style, may commend it.

Since there does seem to be so much of real value here, certain omissions are rather to be deplored. Especially strik-

ing is the fact that there is no discussion of the method of caring for, or of the changing attitude toward, the mentally ill. While the study of the preventive aspects of psychiatry is comparatively recent, the growing recognition of the close relationship of this field to general medicine makes its omission appear equally surprising. The public health nurse will also look beyond the discussion of the relation of bacteriology to preventive medicine for mention of the contribution of sanitary science, to the control of the communicable diseases and of social science in connection with such diseases as tuberculosis and syphilis. She will also miss any reference to the emphasis of the last quarter century on the promotion of positive health as distinct from the prevention of disease. However, these omissions, unfortunate as they seem, hardly justify a criticism of the text as it stands, but rather give cause for regret that there were not one or two more lectures to round out an otherwise excellent and interesting series.

IRMA E. REEVE

Industrial Nurses! A limited number of sets of selected posters on industrial safety are available free of charge from the National Safety Council. Apply to Managing Director, National Safety Council, 20 N. Wacker Drive, Chicago, Illinois.

A Mental Hygiene Reading List for Nurses, made up from their own publications, is available from the N. Y. State Committee on Mental Hygiene of the State Charities Aid Association, 105 East 22d Street, New York.

Those of us who each year struggle over the problem of preparing an annual report will be interested in looking over the practical suggestions embodied in a recent leaflet of the National Probation Association, 450 Seventh Avenue, New York, entitled *Presenting Probation*. Price 10c.

A bibliography on young people's relationships, marriage, and family life is available from the Federal Council of the Churches of Christ in America, 105 E. 22d Street, New York City. Price 5c.

The Committee on the Costs of Medical Care has recently published a report of "Nursing Services and Insurance for Medical Care in Brattleboro, Vt.," including an "Evaluation of the Nursing Program" by Katharine Tucker and Violet H. Hodgson. May be secured from the University of Chicago Press, Chicago, Ill. Price 60c.

A summary report of the *Care of Children in Day Nurseries* for the year 1930 has recently been issued by the Children's Bureau, Washington, D. C., in leaflet form.

The Twenty-Third Report of the Henry Phipps Institute, Philadelphia, for the study, treatment, and prevention of tuberculosis presents the results of thirty studies conducted under the auspices of the Institute. While for the most part extremely technical, those relating to the epidemiology and clinical course of tuberculosis are of interest, particularly "Tuberculosis in Medical and College Students" and "Some Aspects of Prevention of Tuberculosis in Children."

List of Publications on Low Cost Diet is available from the Social Work Publicity Council, 130 East 22d Street, New York. Price 4c.

A Study of Sickness Cost and Private Medical Practice by Donald B. Armstrong, M.D. (pamphlet). Report of a study made by the Metropolitan Life Insurance Company of sickness among a group of their employees for the Committee on the Costs of Medical Care—illustrates once more that medical facilities and resources for low income groups are inadequate and impose too great a relative burden. May, 1932.

BIBLIOGRAPHY FOR INDUSTRIAL NURSES

(Free Reprints of this Bibliography are available from the N.O.P.H.N.)

BOOKS

American Red Cross Abridged Textbook on First Aid. Charles Lynch. P. Blakiston's Son & Co., 1925. Paper, 60c; ill., $1.00.

Discovering Ourselves. Edward A. Strecker and Kenneth E. Appel. Macmillan, 1931. $3.00.

Employee Savings and Investment Plans. National Industrial Conference Board, 247 Park Avenue, New York City, 1929. $1.00.

Health Control in Mercantile Life. Arthur B. Emmons, 2d. Harper and Bros., 1926. $3.00.

Health Maintenance in Industry. J. D. Hackett. A. W. Shaw Co., 1925. $5.00.

Human Nature and Management. Ordway Tead. McGraw-Hill, 1929. $2.80.

Industrial Health. Kober and Hayhurst. P. Blakiston's Son & Co., 1923. $15.00.

Industrial Hygiene for Engineers and Managers. Carey P. McCord, M.D. Harper, 1931. $5.00.

Industrial Nursing. Florence S. Wright. Macmillan, 1919. $1.50.

Industrial Relations Programs in Small Plants. National Industrial Conference Board, 1928. $1.00.

Jurisprudence for Nurses. Carl Scheffel, Ph.B., M.D., LL.B. Lakeside Publishing Co., 1931. $2.00.

The Manual of Industrial Safety. Sidney J. Williams. A. W. Shaw Co., 1927. $2.50.

Medical Supervision and Service in Industry. National Industrial Conference Board, 1931. $2.00.

Personal Hygiene Applied. Jesse Feiring Williams. W. B. Saunders Co., 1931. $2.25.

Personal Administration. Tead and Metcalf. McGraw-Hill Publishing Co., 1926. $5.00.

Public Health Nursing. Mary S. Gardner. The Macmillan Co., 1924. $3.00.

Workmen's Compensation Insurance. Michelbacher and Nial. McGraw-Hill Publishing Co., 1925. $4.00.

ARTICLES AND REPRINTS

Developing Health Services in Small Plants. Violet H. Hodgson. INDUSTRIAL RELATIONS, July, 1931.

Health Supervision in Industry. Health Practice Pamphlet No. 5, National Safety Council, Chicago, Ill. 25c.

A Survey of the Work of Employees' Mutual Benefit Associations. Dean K. Brindage. U. S. Public Health Reports, Washington, D. C., 46:2102-2119, September, 1931.

What to Do in Case of Accidents. U. S. Public Health Service, 1928. 15c.

REPRINTED FROM PUBLIC HEALTH NURSING

How the Official Health Organization Can Aid the Nurse in Industry. W. W. Bauer, N.O.P.H.N. 10c.

Industrial Nursing Service Provided by a Public Health Nursing Association. Kowalke. N.O.P.H.N. 10c.

The Nurse in Industry. V. H. Hodgson. N.O.P.H.N. 10c.

Objectives and Functions of Public Health Nursing in Industrial Nursing Service. N.O.P.H.N. Free.

Postgraduate Preparation for Industrial Nursing. K. Faville. N.O.P.H.N. 10c.

Practical Suggestions for Nurses in Industry. McConnell. N.O.P.H.N. 10c.

Selling Proper Nutrition to Industrial Workers. Comstock. N.O.P.H.N. 10c.

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Promoting Health in a Small Plant. Omilee D. Bradford. PUBLIC HEALTH NURSING, October, 1932.

PERIODICALS

AMERICAN JOURNAL OF PUBLIC HEALTH and the NATION'S HEALTH. 450 Seventh Avenue, New York City. Monthly. $5.00 per year.

INDUSTRIAL MEDICINE. 844 Rush Street, Chicago, Ill. Monthly. $5.00 per year.

INDUSTRIAL RELATIONS. 844 Rush Street, Chicago, Ill. Monthly except December, when issued twice monthly. Subscription price $5.00 per year.

JOURNAL OF INDUSTRIAL HYGIENE. Harvard School of Public Health, Boston, Mass. Monthly. $6.00 per year.

MONTHLY LABOR REVIEW. U. S. Bureau of Labor Statistics. Monthly. $1.50 per year.

NATIONAL SAFETY NEWS. National Safety Council, 20 N. Wacker Drive, Chicago, Ill. $10.00 per year, including membership.

THE PERSONNEL JOURNAL. The Williams & Wilkins Co., Baltimore, Md. Bimonthly. $5.00 per year.

PUBLIC HEALTH NURSING. 450 Seventh Avenue, New York City. Monthly. $3.00 per year. $2.00 to members of N.O.P.H.N.

SURVEY. 112 East 19th Street, New York City. Semi-monthly. $5.00 per year. Survey and PUBLIC HEALTH NURSING—Joint subscription rate $5.50 per year.

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Bulletins and Reports. U. S. Department of Labor, Washington, D. C.
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Are You Afraid Too? Marian Castle in Hygeia, August, 1932. "A sympathetic and reassuring article on cancer."

Art of Occupational Therapy. Horatio M. Pollack in Occupational Therapy and Rehabilitation, August, 1932.

Better Rural Medicine. J. H. Pratt, M.D., in American Medical Association Bulletin, June, 1932.

Children Hurt at Work. G. F. Zimand in the Survey, July 15, 1932.

County Hospital Health Center. M. M. Davis and Mary Ross in American Journal of Public Health and the Nation's Health, August, 1932. A description of the service in Spartanburg, S. C.

Diabetes an Important Health Problem. Charles Bolduan, M.D., in New England Journal of Medicine, July 14, 1932.

Hiring a Doctor by the Year. C. P. Streeter in the Farmer's Wife, August, 1932. The plan of Stewart's Creek, N. C.

Influence of Health in Dickens. L. E. Jordan in the Journal of the Outdoor Life, July, 1932. Tuberculosis is found in several well known characters.

Is the "Appalling Increase" in Heart Disease Real? C. F. and N. W. Bolduan. Journal of Preventive Medicine, July, 1932.

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Nursing Profession in the Field of Health Education. Edna L. Foley, Illinois Arrow, July, 1932.

Public Health Aims and Professional Services of Nursing During Infancy, Preschool, and School Ages. Hortense Hilbert. American Journal of Public Health, August, 1932.

Recreation for Crippled Children. Hortense L. Williams in Recreation, June, 1932. A description of the efforts to provide suitable recreation activities for the handicapped children of Los Angeles.

Relation of the Practicing Physician to the Public Health and Social Worker. W. C. C. Cole, M.D. Hospital Social Service, August, 1932.

Rôle of Psychiatry in the Personal Hygiene of Professional Women. F. L. Patry, Hospital Social Service, June, 1932. Lists seventeen forms of personality difficulty, habit reactions and emotional and social maladjustments which occur in an average or normal group of professional women, for which the psychiatrist can offer help.

Rural Prenatal Program. M. McCuaig. Canadian Public Health Journal, Toronto, June, 1932.

School Children's Nutrition Clinic. Anna E. Boller in Child Health Bulletin, September, 1932.

Scope and Organization of Medical Social Work. M. Antoinette Cannon in Hospital Social Service, August, 1932. Also in same number, *Social Service in a Hospital for Chronics* by Minnie Smith.

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Value of Public Health Nursing as Practiced During the Past Decade. Laura Gamble. Canadian Public Health Journal, Toronto, July, 1932.

What Contribution May the Local Health Organization Render a Junior High School in Developing a Health Education Program? I. G. Smith. New England Journal of Medicine, August 11, 1932.

NEWS NOTES

The twenty-fifth annual convention of the National Association of Colored Graduate Nurses was held in Nashville, Tenn., in August, at the Public Health Lecture Hall of the New Meharry Medical College. After registration, reports of committees and greetings from various organizations, the president delivered the annual address, emphasizing trends in nursing. The morning program included: "Correlation of Social Service Work and Nursing," presented by Grace Harrison; "Treatment of Diabetes Mellitus," by Dr. W. A. Beck. Tea was served in the parlors of the Nurses' Home from 6:30 to 8:00 p.m., with the executive officers of Meharry Medical College and the Nursing Staff of Hubbard Hospital as hostesses. At the open meeting greetings were extended from the Mayor of the city and an address delivered by President Mullaughney of Meharry Medical College.

Two days of the meeting were devoted to institutes with the following program: "Selecting and Eliminating Students in Schools of Nursing," Nina D. Gage; "An Experiment in the Use of Psychological Tests in the Nursing School," Lorraine G. Dennhardt; "Health as an Asset to the Student," Lula G. Warlick. With Mrs. Nannie L. Kemp presiding the second day of the institute opened with "Public Health in the Basic Curriculum" Ruth Hay; "Social Background of Negro Mortality," Dr. Franklin Frazier; "The Rosenwald Fund and Its Work in Public Health," Alma C. Haupt. There was an increasing attendance at each session.

Miss Petra Pinn presided at the Wednesday afternoon session. The following presentations were made: "Hourly Nursing," Jane Van de Vrede; "Social Hygiene and the Negro Family," Alma C. Haupt (substituting for Franklin O. Nichols); "A Public Health Survey of Three Counties in Tennessee," Dr. M. J. Bent.

The following officers were elected for 1932-33: Miss Mabel C. Northcross was re-elected president; Mrs. Nannie L. Kemp, vice-president; Mrs. Eva Simpson Waters, recording secretary; Miss Ruby Woodbury, financial secretary; Miss Petra Pinn, treasurer; Miss G. Estelle Massey, chairman of institute committee.

The next meeting will be held in Chicago in August, 1933.

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A modified policy in respect to the work of nurses has been adopted by the Illinois State Department of Public Health and will be prosecuted with all the vigor that resources permit. Instead of attempting to cover a wide range of territory with the purpose of promoting local nursing services, each nurse will concentrate her efforts in one or a few counties at most. Each nurse will aim primarily at promoting the immunization of susceptible children to diphtheria and smallpox on the one hand and at medical examination of children on the other. Counties which have no nursing services of their own and in which the medical profession and other local agencies join in coöperative programs will be given precedence.

✣

Middletown, N. Y. The Mayor is backing up the Board of Health in urging vaccination against smallpox for all. As a practical demonstration to the people of his belief in the measure, he and all his family were vaccinated at the Board of Health Clinic.

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With the recent appointment as Executive Secretary of Bernard C. Roloff, former Director of Health Education of the Chicago Department of Health, the American Mouth Health Association enters the field of national societies for the promotion of health with an active specific program for the prevention of diseases of the oral cavity.

The American Mouth Health Association is planning a complete educational service for the laity to be made available to dentists, physicians, health workers, social workers, educators, and their respective societies in the promotion of mouth health through the public press, radio, lectures, movies, exhibits, special publications, and through the official organ of the American Mouth Health Association, the *Mouth Health Quarterly*.

✣

Miss Zola Veary, one of the orthopedic nurses on the staff of the Toledo (Ohio) District Nursing Association, has been awarded first prize in a posture contest sponsored by the Children's Hospital of Boston. Her paper "Methods of Teaching Body Mechanics to School Children," received a prize of $50, and the announcement of the award was made at the meeting of the American Physiotherapy Association in St. Louis, Mo., in June.

✣

Mrs. Carl W. Illig of Massachusetts has been made chairman of the Public Health Division of the General Federation of Women's Clubs.

✣

Nursing sisters belonging to the Lady Grigg Nursing Association (which serves Kenya Colony, England) have on several occasions during the past year proceeded to their cases by air. The Wilson Airways Company has very kindly granted special reduced rates for sisters traveling to cases, and in some instances the cost of air travel is lower than by motor at mileage rates.